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PUBLIC HEALTH NURSING

VOL. 44, NO. 9 SEPTEMBER 1952

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PUBLIC HEALTH NURSING
Editor: HEDWIG COHEN, R.N.

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PUBLIC HEALTH NURSING is the official magazine of the NOPHN. At the Biennial Nursing Convention in June 1952 the membership of the NOPHN voted to dissolve the organization and transfer its programs and assets to the newly formed National League for Nursing. Until a ruling is received from the New York State Supreme Court the NOPHN must remain a legal entity and the magazine come out under its auspices.

In January 1953 the National League for Nursing's new official magazine NURSING OUTLOOK will make its appearance. This will continue the coverage of PUBLIC HEALTH NURSING and will also carry material in the overall fields of nursing education and nursing service. Subscription rates of NURSING OUTLOOK are $4.00 per 1 year and $6.50 per 2 years. For foreign subscriptions add $1.00 per year; for Canadian, add 50 cents per year.

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By **RUTH B. FREEMAN, R.N., M.A.,** Associate Professor of Public Health Administration and Head of Division of Public Health Nursing, Johns Hopkins University School of Hygiene and Public Health. 337 pages. $3.50.

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By **MARY E. TANGNEY, R.N.,** formerly Diabetic Supervisor, Hartford Hospital, Hartford, Connecticut. 259 pages, illustrated. $2.75.

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AGE	NO. SUBJECTS EXAMINED	NO. WITH SCURVY	% WITH SCURVY	NO. WHITE SUBJECTS	NO. WITH SCURVY	NO. NEGRO SUBJECTS	NO. WITH SCURVY
0–15 da.	360	0	0	174	0	186	0
16–30 da.	90	1	—	41	1	49	0
1 mo.	99	0	0	48	0	51	0
2 mo.	90	2	2.2	34	2	56	0
3 mo.	69	3	4.3	31	3	38	0
4 mo.	79	2	2.5	26	1	53	1
5 mo.	73	12	16.5	25	3	48	9
6 mo.	53	13	24.5	19	5	34	8
7 mo.	54	10	18.5	22	7	32	3
8 mo.	40	5	12.5	18	2	22	3
9 mo.	38	10	26.3	12	4	26	6
10 mo.	41	5	12.2	16	0	25	5
11 mo.	40	3	7.5	12	0	28	3
12–23 mo.	177	3	—	68	1	109	2
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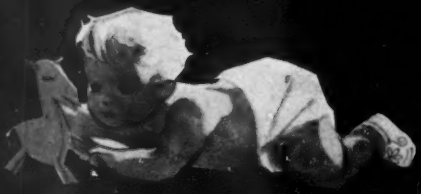

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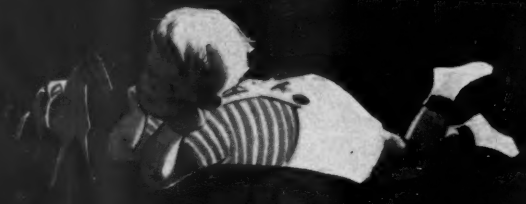

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Witness the Four Hundred

THE CHRISTENING of the National League for Nursing occurred in Atlantic City under the most auspicious circumstances. Tables displaying posters and leaflets about membership in the NLN were set up at the entrance to Convention Hall. Here flocked conventioners, intent on enrolling as members in this important new organization which had just been born. During the first afternoon, and all through the next day after the voting, *more than four hundred people* became new members of the NLN. Others, already members through NOPHN or the NLNE, took leaflets to interest their friends.

Does it not seem that this remarkable demonstration of popularity clearly shows how much the National League for Nursing is wanted and needed? Here at last is the machinery for all interested persons to work together to improve organized nursing services and education throughout our big country and in our state and local communities. Nurses and community leaders are quick to recognize this fact, although they also know that they will have to become a part of the new organization by joining as members.

The more agencies and individuals who become members, the more NLN will reflect broad opinions and develop broad programs of work. That broad opinion and support will bring to NLN the strength to shape its program to meet the needs and the problems involved in providing the best possible nursing service to our people.

Within the organizational framework of the NLN are the Departments of Hospital Nursing and of Public Health Nursing in the Division of Nursing Services and the Departments of Diploma and Associate Degree Programs and of Baccalaureate and Higher Degree Programs in the Division of Nursing Education. When you become a member of the NLN you join one of these departments.

That means that both individual and agency members (hospitals, schools, public health nursing services) work with others in the department who are interested in the same things. The members elect the steering committee for their department and through departmental or interdepartmental councils decide what is to be done and how to do it: what problems are most pressing, what needs must be met, and how these needs can best be answered. Here the individual and agency members will make their greatest contribution through combining their experience and know-how.

In a way it may be said that our infant NLN starts life with a fair amount of security. It already has members—more than twenty thousand individuals who belonged to the NOPHN and the NLNE—and more are joining daily in all departments. It is not too optimistic to hope that the NLN can more than triple its individual membership by the end of 1953.

General and private duty nurses see an opportunity to extend their effectiveness in organized community nursing services through the Department of Hospital Nursing. Although the formation of the Department of Industrial Nursing is under study and not yet a reality, individual nurses believe that by joining now they will bring such a depart-

ment into being more quickly. Upon petition of the psychiatric nurses the NLN board has already formed an interdivisional council for improvement in this field of nursing service and many are joining to swell the ranks of this council. Public health nurses now see wider scope in the NLN. Nurses in the armed forces also find in the NLN a way to tie their work more closely to other community nursing services. And so it goes; each group has its own interests and its own compelling reasons for joining the NLN.

Then there's the community leader—the board member, the person who is just plain interested in what his or her community is doing about its nursing services. They want to take part. We want them, for they represent the consumer's opinion and needs.

The NLN is also fortunate in its agency members. NOPHN brought to it more than 400 such members from among public health nursing services, both voluntary and tax supported. The forty-seven schools, members of the Association of Collegiate Schools of Nursing, are now members of the NLN's Department of Baccalaureate and Higher Degree Programs. At a meeting during the convention NOPHN member agencies voted to ask the NLN board to form a council of public health nursing agencies within the Department of Public Health Nursing. This request was granted. At other meetings representatives from schools, departments, or divisions of nursing education, and from hospital nursing services indicated their interest in joining the NLN. They have suited the action to the word, for every mail brings inquiries about agency membership.

Here again it is not too optimistic to expect that 1953 will see new agency members in all departments of the NLN, for they too recognize what the NLN can do for them and that it presents an opportunity for them to benefit from the experience of working with others.

The next year or so will be a period of growth for our new NLN. To make it strong it must have members—many members to reflect what the majority wants, and what they can do to improve organized nursing services and education in every community.

Nursing Outlook

WE ARE PLEASED to announce that *Nursing Outlook,* the NLN's magazine, will make its appearance in January 1953. One of the earliest decisions made by the Board of Directors of the National League for Nursing was that there be an official magazine for the new organization—a magazine that would reflect the philosophy and ideals of the NLN and report on its activities, a magazine devoted to all aspects of organized nursing services and education.

In the past year several committees at different times have considered the type of publication that would best serve the NLN and its membership; the committees also considered ways in which the magazine might be produced most efficiently and most economically. Everyone agreed that it would be valuable for all the professional nursing magazines to be published by one publishing company. After reviewing this idea from many angles the Committee on Agreements for NLN recommended to the NLN Board of Directors that it investigate the possibilities and ask the American Journal of Nursing Company, which publishes the AJN and *Nursing Research,* to publish the NLN magazine. The suggestion was well received by the boards of the AJN Company and the NLN and the two have worked out mutually agreeable arrange-

ments. *Nursing Outlook*, therefore, will benefit from the many specialized skills available through the AJN Company.

Nursing Outlook will continue the tradition of PUBLIC HEALTH NURSING in serving the public health nurse and all those interested in public health nursing services in their communities. In addition, it will carry articles on new developments in nursing education necessary to meet changing needs of the times; articles with emphasis on preparing nurses for administrative and teaching positions; articles for those responsible for the development and administration of hospital nursing services; articles for board members and trustees and other people concerned with nursing.

PUBLIC HEALTH NURSING will be published throughout 1952. Unexpired subscriptions will be completed with issues of *Nursing Outlook*, so if it is time for you to renew your present subscription to this magazine it will be to your advantage to do so now. In effect, *Nursing Outlook* will be the successor to PUBLIC HEALTH NURSING.

State Reorganization

More than five hundred representatives of state nurses associations, state leagues of nursing education, and state organizations for public health nursing attended a postconvention special conference in Atlantic City on state reorganization. Ruth Sleeper, president of the National League for Nursing, which was then only a few days old, and Mrs. Fannie T. Warncke, president, California SOPHN, presided.

There was general agreement that in organizing a state league for nursing the present state league of nursing education does not necessarily have to be used as the foundation. Either the SLNE or the SOPHN might be used, and many representatives expressed a preference for starting the SLN as a new state organization, not basing it on any now-existing organization. State groups planning for an SLN were urged to seek legal advice concerning both the organization of an SLN and the dissolution of the state organizations that will transfer their programs and members to the new SLN.

It was emphasized that only members of a now-existing state organization can vote on whether that particular organization will dissolve, but that every member of an SOPHN, an SLNE, and any other state group transferring to the SLN should have the opportunity to vote on the organization of the new SLN. Also highlighted was the importance of making sure that NLN charter individual members, who become SLN members when an SLN is formed, have the opportunity to plan for the SLN, to vote on its organization, and to be represented on the first SLN board and committees.

Every state was urged to organize a committee on agreements if it does not already have one. This committee would be responsible for securing legal advice and making agreements about the following: how to organize the SLN; how to transfer funds from the SLNE, the SOPHN, and any other state group planning to go into the SLN; planning the budget and initial program for the SLN; how to secure headquarters space and employ an executive secretary, parttime or fulltime; how to elect the initial SLN board and committees; and what procedure to follow for nominations before any local or district leagues for nursing are established.

Members of a panel explained that until a state league for nursing is organized, persons who want to join the NLN should send their applications for national membership and their dues directly to the National League for Nursing, 2 Park Avenue, New York 16, New York. Persons joining the SLNE or SOPHN should send their applications and their dues directly to the respective state organization. But once an SLN is organized, NLN individual members will be required to join the SLN. After that individual members will join the SLN and NLN at the same time, sending applications and dues for both to the SLN (to the district league for nursing if one is organized in the area). Until a district league for nursing is organized members will join through the SLN. SLNs and SOPHNs were urged to continue their present programs until the SLN is organized.

Work Conferences Promote Growth

MARGARET L. SHETLAND, R.N.

MUCH IS being said and written about "group dynamics." To some people this term means the use of such particular technics as buzz sessions, postmeeting evaluation reports, process observation, and the rest. To others it means a new way to manipulate people to get them to want to behave in the way the manipulator determines. Perhaps more constructively it means a study of the processes of change and development in groups, of how to understand and use these processes to the satisfaction of all people concerned.

The principles and most of the methods used are far from new, although the organization of these principles into a science of systematic study and evaluation is more recent. Group dynamics represents the synthesis of many intellectual disciplines, some of which are political science, sociology, psychology, and anthropology. Practical conference experts, people like Mary Parker Follett, Eduard C. Lindeman, and Elton Mayo, have made significant contributions. Probably the most important single figure in the development of an organized science of group dynamics was Kurt Lewin. His studies of the effect of various types of leadership—autocratic, laissez faire, and democratic—on group productivity are social science classics. As director of the Research Center for Group dynamics at M.I.T., Lewin was the center of the group of social scientists who developed the Bethel program for studying groups and training leaders. Since that time many universities and colleges have developed programs for studying group processes. These programs have much to offer people in administration, supervision, and community services and are being used more and more as resources for improving inservice education and other activities.

Democratic supervision in public health nursing has for a long time recognized the principles basic to the application of knowledge derived from the field of group dynamics. Probably the essential idea is one that is basic to all nursing today—simply a belief in the integrity of people and in their ability to identify their own problems and find valid answers to them. Although we undoubtedly are awkward and inept in putting this idea into practice it is probably one of our deepest beliefs.

With this belief at the base the application of what we know about group process becomes flexible and dynamic. It is not a question of what is the right way, but rather of what technics we can use to make it possible for this particular group of people, in this particular situation, to be as free as possible to identify their problems and to perform the tasks they have selected for this conference. A method that would facilitate the work of one group at one time and with a particular purpose might be blocking in another group, or even to the same group at a different time or with a different purpose. It is in relation to this point that a word of warning is needed. There seems to be a tendency on the part of some people to pick up and apply certain "group dynamic" technics without careful application of the essential criterion of appropriateness to the purposes of any particular group at a particular time. Every process must be scrutinized in terms of its effect on group purpose and accomplishment rather than as an intrinsically good or bad technic.

APPLICATION OF group process to staff education is based on the idea that the

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worker closest to the job is in the best position to identify problem areas. It is still too common a practice for administrators to decide that the staff needs more information about this, that, or the other new or perhaps unsatisfactory service and to call in someone to give a lecture. This type of procedure has practical as well as philosophical limitations. It is true that the lecturer can give information probably in a more orderly and organized fashion than would emerge from a group-centered method. This type of presentation is, however, more logical than psychological, as it is based on the false and rather brazen assumption that the specialist can anticipate the substantive problems of the worker closest to the job. A question period following this type of presentation does not involve participants sufficiently.

It is well demonstrated that the mere possession of knowledge has little effect on behavior. Good group process makes it possible for the staff to identify the problems with which they need help, to determine the type of help they need—that is, lecture by a specialist, discussion among themselves, reference material, conference with consultants, et cetera—and to work out ways to modify practice. In this type of program, content is organized around needs which people see rather than being presented for its own sake; it is probably work-centered; analysis and application are always part of the process; leadership shifts and is group- rather than administration-centered; leadership and group participation are equally as important as content. Consistent use of this approach to in-service education might well result in a more creative job by everyone.

During three years as educational director in a state health department, the writer had an opportunity to experiment with group process in inservice education. Several series of work conferences were organized and out of them grew experiences that convinced the people concerned of the value of this type of group-centered conference. There were some, of course, who thought that much more could be accomplished through traditional conferences with organized agenda loaded with lectures. There were also those who believed that group-centered methods were all right for supervisors or senior advisers but not for the staff nurses. As situations were provided in which various groups had opportunity to think and talk together about their problems the skeptics began to have more faith in people and in the process.

Although we learned many things there was always more to learn. One thing we found out early was that every conference was unique and had to be planned differently from others. It is always a temptation to become attached to a method that was successful in one conference and try to foist it on another. It is necessary to assess any methods continuously in terms of the purposes and group involved in a particular conference. Successful experiences certainly help us learn as long as we evaluate them in terms of principles.

WE ALSO learned that although it is difficult to do, it is essential and possible to provide for shifting responsibility for planning and structuring to the staff group. Preplanning committees can function continuously through the conference as steering committees, and can develop into planning committees for the next conference. By adding new members gradually the membership of these committees can be stable enough for continuity and flexible enough to provide for change, at the same time promoting wide participation and opportunity for leadership development.

Possibly the continuing activities of these groups are of as great significance as the conference itself. It is easy to become enthusiastic and stimulated during the excitement of the conference. The real test of value is in on-the-job application. Interim committees, with a real job to do, provide one way of channeling what could easily be only sporadic enthusiasm through continuing activity.

This type of group-centered leadership is possible only when administration is willing to share control and is able to go along with ideas that are different and may even seem questionable. This is the real test of administrative philosophy, and actually what may seem like mistakes from some points of view may be made. To some people this is

upsetting, but is administration infallible? And it seems that there is bound to be more chance that more people are thinking and of real creativity in the type of sharing we are discussing.

It was our experience that everyone needed considerable orientation to her role in a group-centered conference. The next generation may be more skilled in group participation than this one which too many times is not even comfortable in a group-centered situation. The staff people needed help in developing the feeling that their ideas were really important to administration. Without considerable warm-up in getting across the idea that what everyone thinks is the real potential the group tends to hash over old policies and old ways of doing things without real evaluation. This idea must be conveyed in action and conference structure as well as in words. Possibly if we were skillful enough in the former we wouldn't need to talk about it.

One way of doing this is the use of resource people. Every participant in such a conference is a resource person and the person closest to the job is the most important. However, she is likely to be inarticulate and possibly insecure in her role as a resource person. She needs support in her new role. The conference director can help to shift the responsibility of the conference toward the participants in the many ways the conference is organized, in introductions, in steering committee meetings, and by her general attitudes.

ON THE OTHER hand the expert, consultant, and administration groups should understand that this conference is not their opportunity to win converts and that their role is the same as everyone else's. This type of conference is doomed to failure if administration sees it as an opportunity to convert staff to a way of thinking rather than honestly trying to provide the machinery for the staff to work out problems. This use of supposedly democratic methods for autocratic purposes is dishonest and is usually sensed by the participants. The status person needs to know that prefacing every remark with "I shouldn't talk so much" doesn't make it any better if she does dominate. Some consultants go to the other extreme and refuse to participate even when they could make a helpful contribution. Everyone needs help and continued practice in learning how to participate helpfully without dominating or failing to share ideas.

Just as we found that it was necessary to provide some orientation to the roles of the participants we found that some planning had to be done in relation to leaders and recorders. We never were able to decide on the best way to select people for these responsibilities. When leaders and recorders are selected before the conference there is an opportunity for some pretraining. This usually, although not always, resulted in a better selection than would be made by the groups and the training period usually resulted in improved leadership. However, this process foisted leadership not of their choosing on the group and in some instances postconference evaluations revealed group and leader dissatisfaction with this interference.

On the other hand, in a short conference there was insufficient time for groups to make good choices and although an attempt was usually made to provide concurrent training for leadership teams almost disastrous results were experienced in some instances. When groups can select leaders by letter, sociograms, et cetera, before the conference, and training is provided for these leaders, the results are usually good.

Another problem encountered was in relation to how much preplanning of program is desirable. On the one hand was the reality of the expense of agency time and the idea that it should be utilized as economically and effectively as possible. This reality tended to push us toward considerable structuring in the form of setting up topics for group discussion, et cetera. On the other hand, there is the philosophy that a group is something more than, and different from, an aggregate of individuals and that filling out questionnaires does not fulfill the same purpose as interaction in the identification of problems. Another thing we found was that in responding to questionnaires people tended to list problems they wanted solved, but not neces-

sarily those in the solution of which they wanted to participate. Also problems that seemed important when a questionnaire was filled out in February frequently seemed to have less priority in May when the conference was held.

We found questionnaires had two values: (1) to stimulate thinking about problems in the area of the conference topic (2) to provide some clues to the general type of resource materials and people to secure. If questionnaires are to be used for these purposes and not to set up topics for group discussion the purpose should be understood by participants. Otherwise they will be disgruntled if asked to identify problems again at the beginning of the conference.

OUR EXPERIENCE indicated that the time spent in doing a problem census, categorizing problem areas, and forming groups in terms of the areas identified had values. For one thing, it gives meaning to the principle that everyone's ideas are important. Then, too, it frequently provides a fresh and different approach. We learned some things about this process. It is almost always painful and timeconsuming if it is done with honesty and with the infinite patience required by everyone concerned to try to capture ideas and not do violence to them in fitting them in categories. Sometimes the idea that seems obscure when finally clarified turns out to be the spark of creative thinking that sets the conference on a new way of thinking.

The integrity of the leader and blackboard recorder in this process is an object lesson in belief in people and respect for their ideas. The leader can never be satisfied with compromise or until she is sure that the words on the board really satisfy the individual or group whose ideas they represent. If the process seems to drag out too much, which it frequently does, it may be taken over by a steering committee. However, an agile leader will try to hold the interest of the total group in what is really an experience in democratic process that should be valuable in itself. An experienced leader, sensitive to group reactions, learns ways of shortening the process without jeopardizing ideas.

The physical environment of the conference contributes considerably to the feeling of groupness. If possible it pays dividends to get the group into a situation where they live together, apart from other people and distractions. We found that more could be accomplished in two uninterrupted days in this type of isolated environment than in the same amount of time spaced over a longer period.

We learned that time spent in recreational activities was not wasted. Minds continued to work and come back fresh and alert. Some of the workshop songs captured ideas in words better than the fine formal reports.

And a word about reports. We had a tendency to be almost compulsive about getting everything on paper, but gradually learned to realize that the great value of such a conference is not in the printed report but in the growth that occurs in each participant. And we learned to relax a little about trying to evaluate tangible outcomes.

There is much more that we all need to learn about ways of setting up situations where people can be free to tackle their own problems. In achieving this we need to be flexible in the manipulation of situations and things, but rigid in our determination not ever to manipulate people to secure outcomes previously determined by others. The planning of such conferences is more strenuous than the traditional conference. Its success depends upon sensitiveness to people and their needs and an ability to adjust to changes on the spot. Few people have this ability, although participation in conferences like this helps to develop it. It is a comfort to know that in a group-centered conference responsibility for success or failure lies in the group, not the leader, and that the group develops understanding of the shortcomings of a leader whom it trusts.

In conclusion, let the unsolicited comments of a young staff nurse tell her reactions to her first experience in this type of work conference.

"For two days this month Miss X conducted a most interesting meeting, with participants exchanging ideas and suggestions in the field of public health. Many levels of

(Continued on page 521)

School Health Trends As They Affect the Nurse

SAMUEL M. WISHIK, M.D.

IN THIS PAPER space permits discussion of only four aspects of school health and their implication for public health nursing. The aspects chosen are (1) communicable disease and attendance control (2) the health examination (3) special education (4) follow-up for health improvement.

Communicable disease and attendance control

In former days communicable disease control in schools meant exclusion of patients well beyond the time when there was any possibility that they might be infectious. Contacts were also excluded until no chance remained that they might be coming down with the disease and in turn be infectious to other children. In recent years the period of exclusion of the patient has been reduced. For diseases whose infectious period is sharply self limited the exclusion period is not longer than the duration of known infectiousness. For example, patients who have had chicken pox are now permitted to return to school even though scabs remain on the skin.

With certain diseases whose causative bacterial organism is known, patients were formerly excluded as long as laboratory tests continued to be positive for the presence of such organisms. We have learned that the finding of organisms in laboratory tests is not necessarily correlated with the potential infectiousness of the patient, nor is absence of bacteria correlated with noninfectiousness of the individual. Many health departments or school health services no longer require negative cultures from the nose and throat before patients with certain bacterial diseases can be free from isolation or readmitted to school. The patients are kept out as long as they are acutely ill and for a short period of convalescence thereafter.

The changes throw increasing responsibility on the school. In former days the margin of safety was broader because pupils were kept out a longer time. They were less likely to slip by and come back to school while still in an infectious state. Under the present procedure the likelihood is not very much greater but the interpretation to school administrators, teachers, parents, and the general public of the difference between the infectious and noninfectious child becomes more difficult.

BECAUSE THREE fourths or more of all school absences are caused by or are related to illness it is easy to understand why attendance control was so often closely tied in with the school health program. The school attendance machinery should be in the principal's office or in some other administrative location. On the other hand, all absences caused by illness should be reported to the health room and should come to the attention of the school nurse or some other person in the school who has time set aside from other duties for health work. The absences, their occurrence, their duration, and their cause should be recorded in the health record. The nurse, therefore, must be on the lookout for readmissions about which she should have special concern. A child convalescing from a recent attack of rheumatic fever, for example, should be called to the health room immediately upon his return to school and referred to the school physician. The information on absences becomes part of the overall health picture of the child.

Not only those ill with infectious diseases

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but also their contacts are excluded from school less than they were formerly. In previous years those in close contact with most diseases of childhood were excluded from school for the full length of the incubation period after the last possible exposure. This would mean, for example, that the brother of a child with chicken pox, measles, or mumps would be kept out for almost a month, and in the case of scarlet fever or whooping cough sometimes several months. Yet for most of the school days lost by such practice the excluded children were not infectious.

The present pattern in most school systems is to permit the contacts to come to school until they themselves become patients. They are then excluded in the same way as the original patient was. This imposes a responsibility on the school to interpret to the parents the importance of their watching the siblings, learning the approximate time when to expect symptoms to develop and what symptoms to look for, and keeping a child home at the first sign or suspicion of illness. The school carries the additional responsibility of being the second barrier and observing these children in the same way as the parents do. This means that the school teacher has had earmarked for her a spread of days—perhaps three, four, or six days—during which a child is a candidate to come down with symptoms and during which she keeps a more careful eye than ordinarily on the child. Daily observation and immediate exclusion on suspicion of symptoms are therefore substituted for the previous prolonged, cautious exclusion.

What the role of the school nurse is in connection with such changed practices cannot be answered too easily. One can understand why school administrators and teachers complain that their duties are burdensome enough without having this added responsibility and also that the skills asked of them are somewhat beyond their own fields of work. On the other hand, it might be argued that no more is asked of the school teacher than any parent is expected to know, that the school teacher does a more effective job in her classroom teaching when she is on the alert to the health status of her children, and that the nurse would be removed from other tasks if she were expected to make a daily inspection of all contacts.

The health examination

If asked which is the more valuable part of an investigation into an individual's health, the medical history or the physical examination, many presentday physicians would vote for the former. At least they would all agree that the history should not be omitted. In recent years school health programs have been placing greater emphasis on history taking and on discussion with parents and with children themselves in preference to the assembly line, rapid fire physical examination of former days. The history from parents and from children may be taken at the time of the physical examination. Often it is advisable for parents to have leisure to discuss the questions on the history form at home with each other and together with the child and to prepare it in advance of the examination. Any language difficulty that exists can be overcome by such home conference. The nurse can help to interpret the questions and to obtain some of the history.

Because of the emphasis upon parent attendance at the physical examination, not merely for taking history but also for interpretation of the findings and of steps advised, greater opportunity now exists for relationship between nurse and parent over and beyond any home visiting that the nurse may make. The nurse cannot afford to remain merely an assistant who stands at the physician's elbow during the examination. She participates in a separate interview with the parent and child or in a combined interview with the physician, parent, and child.

The frequency of the school medical examination is a question about which there has been and continues to be much discussion.

Under the impetus of the World Health Organization definition of health, with emphasis on promotion of positive health, a school health program which limits its horizon to the discovery of defects is no longer in keeping with the advance guard. There is no child for whom health promotion would not be advantageous. Therefore, to the extent that

the school health examination may be a vehicle for promotion of positive health, it should be made available to all children. This means that the periodic routine examination for all children should be given at as frequent a rate as possible within our means, consistent with maintenance of high quality of work and in the light of profitable return in promotion of health. We do not think it necessary to have a physician examine a child every week in order to help that child toward health improvement, although we do believe that some health education—woven into the child's schooling or living daily—is not unreasonable. Similarly, it may not be necessary to have every school child examined physically every year in order for that child to receive the benefits of a program of health promotion. We do not know the optimum interval between health examinations or the optimum balance between the health examination and other aspects of health education. There is much need for careful evaluation of these questions in the light of our newer philosophy of health promotion.

The change from the quick superficial examination to a more thorough one, accompanied by interpretation to the parent, means that more time is needed for each examination. This makes it practically impossible to follow the onetime practice of completing all examinations during the first weeks of each school year, nor is it considered desirable to concentrate the examination procedures in such fashion. The responsibility falls upon the nurse to schedule her examinations to arrive at a balance between the examinations which are due on a routine basis and those based on special referral. In general, the specially referred child receives priority. This priority, however, should be tempered by an appraisal of the urgency and should not result in prolonged postponement of the routinely scheduled examinations.

THE NURSE ALSO has a responsibility to encourage teacher observation and participation in referral of students for health appraisal in the area of emotional health. Whether such referrals are made to the school physician depends upon the counseling and child guidance program of the particular school system. In any event, at least the interplay between emotional and physical health falls within the purview of the school physician and nurse. The first response on the part of teachers to a campaign for teacher referral is over-referral. Under the stimulus of the new interpretation that has been given to them, and in a desire to cooperate, they refer many children unnecessarily or inappropriately. This is all to the good, as long as the excess referrals are handled properly by the school health service. Usually every child referred is screened quickly by the school doctor or nurse in order to determine whether an examination should be scheduled. Particular attention should be given to those children for whom an examination is not considered necessary. In every instance the findings of the screening procedure should be reported to the teacher rather than a mere statement of rejection of scheduling. The interpretation of the so-called unnecessary referrals results in an increasing amount of discrimination on the part of the teachers and is one of the most effective devices for improvement of effectiveness of teacher observation, teacher understanding of health, and teacher referral for school health examination.

In addition to routine periodic scheduling and special referral, the health appraisal of school children includes certain screening tests such as vision and hearing. Present practice still calls for an annual vision test and for hearing tests every one, two, or three years. There is no certainty about the optimum periodicity of such examinations. Probably vision testing should be done more frequently than hearing. Probably hearing testing should be done more frequently in the younger children than in the older.

Further study is necessary before one can arrive at conclusions. At whatever intervals agreed upon, the routine screening tests must be supplemented by other casefinding methods.

Special education

Another significant trend in school programs which relates closely to the school health service and, therefore, to the work of the

nurse in the school, is the increasing emphasis on special education for handicapped children. More and more state departments of education have units and personnel concentrating attention on special education and giving consultation and help in the development of such programs in local school systems. Included are education for the hard of hearing, the visually handicapped, the orthopedically handicapped, the cerebral palsied, the mentally retarded, the emotionally disturbed, and others.

The expansion of programs of special education permits a wider range of educational placement for handicapped children. In former years home instruction with all the limitations implicit in such a program was the first and sometimes last and only recourse for the handicapped child. At present the requirements for admission to types of educational setting other than the home are being liberalized. In the order of increasingly normal settings are home instruction, hospital instruction, the special school for handicapped children, the special class in a regular school, the divided program which permits the child to spend part of his day in a regular class and part in special classes, the modified program individualized to meet the needs of a handicapped child in a regular class, and finally, the regular program in a regular class.

This philosophy of moving a child toward a normal setting in so far as possible while at the same time placing him in the specialized setting that meets his special needs to the fullest extent means that more careful decisions on the placement of each child become necessary. A fuller participation of health personnel results from recognition of the fact that health is the prime basis for the adjustment of the school program. Not only the initial placement but the duration of each special placement becomes important and periodic reevaluation of the medical status in the light of the educational placement is indicated.

Another feature of special education for handicapped children is the development of more specific and more appropriate criteria for placement of children in one setting or another. For example, in former years—and still in many places—the decision on whether a child should be in a lip reading class was made entirely on the basis of number of decibels of hearing loss. Now it is recognized that two children with the same amount of hearing loss have different reactions to lip reading. For one, lip reading comes easily and is helpful. For another, lip reading is difficult and confusing. Careful attention to other factors in the child's personality and past experience, in addition to the mere amount of hearing loss, is necessary before the most appropriate school placement can be arrived at.

The decision on placement of a child in special units for cerebral palsy may depend, among other factors, on the amenability of his condition to improvement or even on the availability of specialized staff time. It may be that the caseload of the physical therapist is filled but that of the speech therapist is not. The combinations of difficulties which are present in any cerebral palsied child may have to be considered in the light of available staff service before recommendation for placement in a special unit is made. Here again, the medical evaluation of the child's condition plays a prominent role.

IN THE EDUCATION of handicapped children greater teamwork is being developed between the educational disciplines and those which may be more closely allied to health care. The services of a speech therapist, a physical therapist, an occupational therapist, a regular teacher, a teacher for the hard of hearing, et cetera, must be dovetailed one into the other. The medical and nursing personnel, too, work with the other therapists and with the educators to help meet the total needs of the handicapped child most effectively. With the increase in number of special classes for handicapped children a question may be raised about the nurse's role in health supervision of children in these classes. In some schools these classes receive special medical services, with the result that the nurse feels superfluous and actually gives less attention and time to the children in these units than to the nonhandicapped children in regular classes. This is the opposite

of what one would desire since, if anything, these children have greater health needs than the others. It seems to be a reasonable objective in most situations for the regular school health service to be responsible for the health supervision of all children in that school, whether handicapped or normal, whether in a special or in a regular setting.

Handicapped children usually need special vocational planning and counseling, and this becomes a major element in their education as they grow older. Health evaluation must be an important part of such vocational aid. One useful device is the holding of a vocational planning staff conference early in each handicapped child's school career and periodically as indicated thereafter. The nurse plays a part in the planning and conducting of such conferences.

The current philosophy in connection with handicapped children is one which aims at total rehabilitation. It does not focus upon one or another component—upon medical correction alone, upon psychological adjustment alone, upon merely special education—but upon all factors, social, economic, vocational, educational, and health combined. Increasing responsibility is placed upon the nurse, as it is upon the others, to work with the other professional disciplines toward this end.

Follow-up for health improvement

School systems have long had difficulty in obtaining follow-up correction of certain health deficiencies discovered by the school examinations. When the chief reason for the difficulty has been inadequacy of resources in the community, some schools have organized treatment services or health departments have set up treatment services in the schools. Dental correction is probably the prime example of this. Others are the holding of special otological clinics for follow-up of audiometric hearing testing, treatment of children with cerebral palsy, and the care of the common nuisance conditions.

The development of treatment services within the school has implications for the nurse. It means that clinical duties are added to the tasks that she had before and also that more of her time may be tied up in the school and less time permitted for outside work.

Home visits are being made in different school systems by nurses, by home visiting teachers, and in some instances by social workers employed by the school department. Confusion often results from the multiple home visiting—confusion to the family and to the professional personnel. Evidently respective functions have not been clearly defined.

It is an obvious functional oversimplification to say that the nurse makes a home visit in connection with health, the teacher in connection with education, and the social worker in connection with social or emotional problems. Such a differentiation cannot always be sharply made and one hopes that it is not kept too discrete. Each, however, should retain the primary focus of his particular professional competence and give consideration to related factors extending into the other disciplines. If all work together they will fortify rather than neutralize one another's work.

A question that is frequently asked is "How many students can one nurse cover?" The answer, of course, depends on a number of factors, such as the available community health services, the home visiting patterns, the health counseling and attendance control practices in the school, the presence of a health coordinator in the school, and the classroom teaching demands made upon the nurse. Public health nurses have been trying to give full consideration to such factors in arriving at an answer to the question. As soon as the solution seems within sight, however, the nature of the school health service as well as the educational program as a whole is modified. One would not ask the educational program to stand still. In the same way as education is not static but moves onward, the nursing profession cannot stand still and wait for final answers but must adapt itself in flexible fashion to the difficult and ever changing context of the school.

A Psychosomatic Approach to Maternity Care

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TO ME THE psychosomatic approach to maternity care means a *total* approach. It means the recognition that to each pregnant pelvis there is attached a personality. You need no reminder of the swelling abdomen, the fetal movements, the changing breasts, and the many other physical alterations which accompany pregnancy. This somatic half of the obstetrical experience has certainly had the giant's share of interest, research and therapeutic application. As a group, we have spent very little time investigating, considering, and working with the inner, the psychological, feelings which every pregnant woman experiences concurrent with her physical changes. And yet much of what I say will be familiar to you. It is material we have attached minimal importance to, however, because of the greater emphasis in our training on the somatic. It has been said, appropriately, that it is far easier to ignore the obvious than to relinquish the traditional. I think that we are met today to look carefully through the eyes of all our combined experiences at the obvious, and to attempt to relegate the traditional to a more balanced position in our maternity programs.

We can begin with a brief look at the emotional factors of conception. Pregnancy can be "planned" or "unplanned." Planning may be on a conscious level, "We decided to have a baby,"—or the more positive, "We wanted a baby." This does not guarantee, however, that the woman's unconscious wishes coincide with her consciously expressed desire to have a baby. She may actually be deeply rejecting of her pregnancy. On the other hand, some women who use contraceptive methods, and, therefore, on a conscious level do not plan for a child, will insert the diaphragm incorrectly, run out of jelly, or "just not bother." We strongly suspect that these women may have strong, unconscious motivation to have children.

The emotionally mature and stable woman can become pregnant for many reasons. She can conceive in order to fulfill her major role in the life process, the role which she has been preparing for since infancy. She may wish to accent the love she has for her husband. She may want a baby because it represents an investment in the future, because through the child she fulfills a duty to society by contributing to race survival. She may want a child because it will carry on family tradition in the broadest sense, or because the baby will afford her an object in which she may invest over a long period of years her abundant love and her interest. This is the picture in the normal, mature woman. On the less healthy side, we have all seen the woman who just gets pregnant: "This is what happens when you get married." We have seen the woman who decides to have a child to keep her marriage, already in a rocky condition, from disintegrating; and the insecure woman who despite a fairly good present marital situation has a child in order to tie her husband to her permanently. We have seen women who want babies as playthings, and even women whose pregnancies become hostile gestures against their husbands or against their parents, especially their mothers. This last is sometimes one of the most important factors in illegitimate pregnancy.

NO MATTER what the basic drives are leading to conception, once pregnancy has occurred certain psychological changes begin. To understand these we first consider emotional factors operating before pregnancy

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occurs.[2] In each menstrual cycle there is the regular, monthly physiological preparation for pregnancy with the hormonal release which prepares the lining of the uterus to accept the fertilized ovum. With this well known physical change there occurs a corresponding monthly pattern of emotional attitudes. During the last half of the monthly cycle women tend to show an increased passivity and receptiveness and a definite trend toward introversion, a turning in of thoughts and feelings. When the woman becomes pregnant this increase in receptiveness and passivity which has occurred transiently each month persists. There is a need and a wish to receive love and support from family and society. This need to take in is perhaps in part shown by the voracious appetite met with so commonly in pregnant women—the old "eating for two." There is also a persistence of the turning in, the introversion, seen as part of the regular monthly sexual cycle. There is an almost characteristic attitude of withdrawal, and a tendency to daydream. The emotions of the pregnant woman tend to be centered on her own body and on the developing fetus.[3] The fact that the fetus has no separate existence from her, cannot be seen, in fact cannot even be felt until the middle trimester, lends a dream quality to pregnancy.

The hormonal changes, the mother's awareness of the developing fetus, and the psychological pattern which we have discussed all direct the pregnant woman toward the development of motherliness. Probably one of the most important factors in the psychological life of the obstetrical patient is her identification or her lack of identification with her own mother. If she has achieved the normal identification with her mother then only is she able to progress comfortably in her pregnancy and in the direction of motherliness. Going hand in hand with this identification with her own mother is the ability to identify with the developing child which results in the wish to love him, care for him, nurse him. If there has been a happy identification with mother then there is a consequent good acceptance of this feminine role. If mother, on the other hand, has been rejecting, overprotecting, or has fulfilled her own selfish needs in handling her daughter, the young woman is very apt to be emotionally immature and is unprepared to do an adequate job of maintaining her pregnancy, delivering her baby, and carrying out the duties of motherhood. This is most important. The girl must adequately identify with her mother or with a good mother figure in order to accept comfortably her feminine role.

Pregnancy has been divided psychologically into two time intervals. During the first four to four and one-half months the fetus is a more or less parasitic part of the mother, to some mothers almost a foreign body. During the last half of pregnancy, however, the mother's attitudes and feelings change. The fetus, although still actually parasitic, becomes an individual apart from herself in many ways, and at this time there can begin a true object relationship, an interpersonal tie which will be of prime importance following the birth of the child. The fetus becomes a baby, a personality, a thing to love, not because it is part of the woman's own body but because it has become another person.

Thus far, then, we have discussed changes in the pregnant woman's own inner emotional structure, plus accompanying attitudes and feelings resulting from her reaction to the symbiotic relationship developing between herself and her child.

If our pregnant woman is physically sound, and is not an unduly anxious, fearful, immature and unstable person, she has enjoyed her pregnancy, has felt fulfilled, and has been a happy member of society. When she goes into labor and the realization comes that the fetus is going to be separated from her, however, she experiences conflicting emotions. We have all heard expressions of great restlessness as the woman approaches term: "I'll be glad to get it over with," "I feel so heavy," "I can't sleep at night." When she actually goes into labor, though, she is faced with her identification with the fetus and the strong emotional attachment she feels for the baby part of her. It is part of her body, and she therefore has anxiety regarding its loss. There are probably strong unconscious feelings associated with the loss of this structure which has been growing within her. Delivery can

be compared in some ways with the amputation of a limb and the feelings the patient has when he realizes that this part of him which has become so familiar and which he has had with him for so long is no longer there. Early postpartum women can sometimes verbalize this feeling of detachment and "organ loss." Some women will say that they are not so happy as they were before the baby was born. Something seems to be missing.

AFTER BIRTH the entire mechanism of the mother has to be reoriented. There are metabolic and hormonal changes with which we are all familiar. There are, again, accompanying psychological changes. The unity which she has felt between herself and her baby, the symbiotic relationship[1] which has developed during this nine-month period, has been suddenly greatly diminished. Again, all of you are familiar with the emotional lag, often associated with depression, between delivery and the onset of lactation. It may result from this sudden loss and from all the changes which the mother's physical and emotional body must undergo. Aid in overcoming these postpartum "weeps" undoubtedly can be given if the mother is allowed to remain conscious during the birth. Many women are able to tell us that they feel a great swelling up of love when they hear the infant's first cry. It seems to reassure the mother and makes her feel some continuity with the before-birth relationship which she had with her child. If she is anesthetized and unconscious, on the other hand, instead of the upsurge of love she may have a sense of loss and emptiness, a feeling of distance between herself and the baby. The infant may seem almost a stranger. Instead of being relaxed and happy the mother may cover up her guilt and anxiety in this new parent-child relationship by becoming overprotective. One of the best reasons we know for natural childbirth is the fact that this separation reaction seems to be less common in the women who are conscious during labor and delivery. Lactation is a means of continuing the symbiosis, the psychosomatic relationship, between the mother and the fetus which has been present during pregnancy. It is the result of a hormonal and psychological preparation. Every mother has an innate need to fulfill this emotional and physical preparedness for motherhood.

Just as the woman's general physical health before conception and the bodily changes of pregnancy may together contribute to physical symptom formation, so do these basic psychological factors plus past life experiences and interpersonal relationships contribute to emotional symptoms in the pregnant woman. To be pregnant is to be fearful, to be afraid.[5,6,7] All pregnant women are anxious to a degree beyond that of the normal nonpregnant woman. Every pregnant woman, no matter how serene, has times of insecurity and anxiety, both in relation to her own wellbeing and to the safe delivery and health of her child. She also wonders what effect her pregnancy, her changing body and mood, will have on her relationship with her husband. If she has sexual intercourse will it hurt the baby? If she doesn't will her husband turn away from her? If she has other children she wonders what effect the new baby will have on the present family group. Pregnant women think of and fear death. They fear pain. They fear hospital procedures and operative procedures such as "cutting," spinal anesthetic, "needles." They are afraid that they may not be strong enough to meet the challenge of delivery. They fear that the child may be deformed, may be feebleminded or otherwise defective. They fear that the child may die either during the pregnancy or at birth. If there have been any attempts to terminate the pregnancy, even mild measures like hot baths or "pills," there are fears of the consequences of attempted abortion to the mother as well as to the child. A great and important fear is that of the responsibilities of motherhood, of bringing up the child.

Another feeling which is probably present to some degree in every pregnant woman is that of rejection. Even the most tranquil and motherly patient will have times when she feels insecure about this developing baby, when she is not completely sure that she really wants the baby, when she is faced with the economic and social responsibilities of taking care of the infant, and when she is ambivalent about her present physical state. She can

verbalize this rejection occasionally, but more commonly she is ashamed of it, or even unaware of it. Some women may develop substitute physical symptoms. There are many observers who feel strongly that the nausea and vomiting of pregnancy may be symbolic of rejection and attempted oral expulsion of the fetus. It seems to be more prevalent in our culture than in others which have been studied. On the other hand, some Indian tribes[4] accept as characteristic behavior the oral "meanness," or in our slang "bitchiness" of their pregnant women. It has been suggested that perhaps each culture has an individual method of handling unconscious hostility toward pregnancy.

JUST AS MORNING sickness diminishes and disappears at about the beginning of the second trimester, so there is a shift in attitude. The verbalized rejection and ambivalence shift to a more positive and accepting mood. We can suppose that the unconscious ambivalence may also be altered. A group of pregnant women[7] were asked to express their feelings about being pregnant at the first missed menstrual period and again during the sixth month of pregnancy. Below are a few examples of such changes.

Initial comment	Shifted to
Didn't care too much for the idea at the time.	Very happy now.
Just accepted it—I'm married and all.	Happy and feel swell.
Oh no!	I accept it.
Upset and worried—tried to get rid of it.	Glad I got it.
Scared.	Not afraid. Glad I'm that way now.
Sick at the stomach—didn't want no more babies.	Happy—want my baby now.
Was very disappointed.	Looking forward to it.

We must not minimize the past in our attempt to understand the pregnant woman in our care. Pregnancy is a period when concomitant factors of emotional stress and physical change are greatest. Many women can defend themselves against these stresses by repressing anxiety and fixing upon the good goal of motherhood. The woman who is unable to rally her emotional strengths, however, is the one with whom we must be additionally concerned. If the woman is already emotionally ill—for example, if she has the neurotic patterning of anxiety hysteria—she may use her pregnancy as she has used other life experiences to convert her anxieties into somatic paths. If she is an obsessive compulsive neurotic, she may have an intensification of her ritualistic symptoms, or she may surprise herself and her physician by having an extremely pleasant pregnancy because in her pregnancy she finds the fulfillment of some of her neurotic need for punishment and penance.

We have seen that there is in every pregnant woman a certain regression toward a more infantile emotional adjustment. If the woman is psychosexually immature to begin with, however, this regression in pregnancy may be extensive and symptom-producing. The difficulties which she had in her childhood in her relationship to her mother and father—her natural attachment to her father, her natural rivalry and anger with her mother—instead of undergoing resolution by the end of adolescence may persist and be carried unduly into her pregnancy and her reaction to it. Our pregnant patient may be too dependent upon her mother who has fulfilled her own emotional needs by keeping the girl immature. The husband may have unwittingly accentuated this dependency. In this event her neurotic secondary gains are threatened by the growing fetus and the child may be rejected as a rival.

Another factor which we have to deal with in the labor and the delivery room has its beginnings back in the early childhood of the pregnant woman. There is sometimes a carry-over of too rapid and rigorous bowel and bladder training. There are many women, as we all know, who are miserable because the involuntary contractions cause pressure on the rectum or because a sudden gush of amniotic fluid is reminiscent of the wetting before bladder training was complete. The woman seems to reexperience early infantile tensions associated with shaming and punishment. She may react with discomfort and anxiety. We

have all seen the woman who cries out, "I'm afraid I'll make a big mess; please let me go to the bathroom," and who seems more concerned with this than with the actual mechanics of labor. Her pelvic muscles do not relax and there may be a more prolonged and painful second stage.

We cannot leave the consideration of the psychodynamics of the pregnant state without emphasizing again that for every conscious anxiety or expressed feeling we elicit from our patient there are many deep unconscious fears and conflicts, inaccessible to direct verbalization. These may be handled by the patient's healthy reaction to motherhood itself, but they may instead erupt and lead to psychosomatic difficulties.

WE THEN HAVE a pregnant woman who, through a combination of psychological and physical factors, is living through a true psychosomatic experience. She may be supported by the factors in her life which have helped her to become emotionally mature, by a good relationship with her parents, by a strong identification with her mother and by a satisfactory and happy life with her husband. She may be bombarded by the troubled and unsatisfactory aspects of her prior life, by her reaction to a rejecting, immature, or overprotecting mother, by an unhappy adolescence, by her own emotional immaturity. Whatever her background, she tends to be more introverted, more passive and receptive than at any nonpregnant time in her adult life. She needs society and husband and family to fulfill her receptive needs in a way she has not needed them since her own infancy. She is given to fantasy, to an enjoyment of her own pregnant, fulfilled body. She is living in a rapidly developing emotional world, in which her love for the new baby crystallizes as her body grows and she prepares to give. At the same time there is a shrinking of her emotional world in terms of harboring an object which only takes from her and which can give nothing tangible, an object which at birth will actually diminish her. In terms of her intense identification with her child, the giving of life is actually the losing of some life. Like other body or organ loss, at delivery some part of her is taken away.

We now come to a discussion of obstetrical conditions with emotional implications which go beyond the natural psychosomatic manifestations of normal pregnancy. There is a good deal of evidence to suggest that some women, because of the above discussed emotional factors, will develop an abortion habit. This may be likened in some respects to the development of accident proneness. Spontaneous abortion must be included in our list of obstetrical difficulties which may have responsible psychogenic factors. Habitual aborters have by intensive psychotherapy been carried successfully to term. Threatened abortion has been averted by hypnosis[5] and by other psychotherapeutic methods. In addition to abortion, there is some evidence that prematurity and stillbirth may have emotional as well as physical precipitants.

The severe nausea and vomiting of early pregnancy has been a common problem. No specific etiological factor has ever been discovered. No therapeutic agent has been found which is universally effective. The symptoms are, for the most part, self limited. Certainly the bulk of evidence is in favor of psychic factors rather than primary metabolic factors. It is interesting to observe that the nausea and vomiting of pregnancy seems to disappear at about the time that the mother begins to feel life and to show body changes. It suggests that an inner change in her feelings occurs when she is able to look upon her baby as a developing individual, rather than as some unseen, unfelt foreign body within her abdomen. When she can invest the baby with object feeling, both overt rejection and morning sickness—which may represent, as mentioned before, a symbolic attempt to expel the baby orally—disappear or are greatly modified.

Late toxemias of pregnancy, preeclampsia, and eclampsia have never been adequately explained. Psychiatrically oriented obstetricians think that there are probably psychogenic factors operating in these conditions and we are all hoping that more extensive research along these lines will be accomplished in the near

future. Heartburn, a common symptom in pregnancy, may also have its psychogenic component. It has long been recognized that the pylorospasm which causes heartburn is functional in nature. One wonders if the woman bombarded by her feelings of rejection and her fears just can't "stomach it." Long labors with primary uterine inertia are found associated with fear, immaturity, and rejection. The woman who has an uncomfortable pregnancy with backache, headache, palpitation, faintness, excessive and bizarre appetite is frequently a woman who is converting her neurotic reaction to pregnancy into somatic symptoms.

NONE OF THIS material is really new to you. All of you have seen the emotionally disturbed woman who has had an unsatisfactory obstetrical experience. In an attempt to demonstrate statistically some correlation between emotional instability and poor obstetrical experience, a study was recently made in Baltimore[7] on 56 white clinic patients in the third quarter of pregnancy. Using psychiatric interviews and projective psychological tests, these women were divided into an emotionally sound group and an emotionally unsound group approximately three months before delivery. The total obstetrical experience was looked at in summarizing the results. The poor obstetrical experiences included postpartum hemorrhage, uterine inertia, stillbirth, preeclampsia, prematurity, antepartum hemorrhage, neonatal death, premature separation of the placenta, and intrauterine death. Of the 34 stable patients for whom delivery experiences could be obtained, 29, or 85 percent, had "good" results. On the other hand, of the 18 patients with unsound emotional adjustment whose cases could be followed to delivery only 5, or 28 percent, had "good" obstetrical experiences. Of the 18 "poor" experiences, then, thirteen were in the unsound group of patients, and only five were in the sound group. It is important to state here that this sample, although small, was a representative segment of the white clinic population, and the study was carried out, in an attempt to avoid bias, in two university clinics and the clinic of a large private hospital. The results were statistically significant and justify the conclusion that women of unsound emotional adjustment will, in all probability, have a much larger number of unfortunate obstetrical experiences than those showing sound emotional adjustment.

The question now comes up: What can we do about these things and how can we utilize our knowledge? The treatment of the emotionally unstable pregnant woman whose fears, anxieties, and hostilities may be strong enough to influence the course of her pregnancy is based first on the recognition that these factors exist. With this recognition a regime directed toward treatment of the problem can begin. A few cases will ultimately be referred to the psychiatrist. The Utopia of maternity care, however, as I see it, is a program in which nurses and obstetricians will be trained to handle the majority of cases competently. They will use their naturally sensitive and sympathetic abilities to identify with the patient. In addition to eliciting such historical information as the date of the last menstrual period or the state of the bowels, they will inquire about her reactions to her first menstrual period as a girl, about her relationship to her mother, about her mother's obstetrical experiences. They will be interested in her life with her husband, in her sexual adjustment. They will concern themselves with her pregnant feelings as well as with her pregnant body. They will let her talk, they will listen carefully and with interest to what she has to say. They will not lecture her. They will gently reeducate and reassure her about her superficial anxieties and conflicts. They will recognize and respect the deep unconscious tensions which she may be battling in bringing this new life into the world.

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Nurse Midwives: The Torch Bearers

HAZEL CORBIN, R.N.

RAPID CHANGES are taking place in maternity care across this country. The "obstetrical factory" is on the way out. Obstetrics is beginning to move out of the era of surgery, deep anesthesia, and forceps. Pregnancy is no longer considered a sickness of nine months' duration but a natural, common, normal function of the body. Hospital designs are being changed to place emphasis upon people and their personalities. Hospital administration policies are being altered to remove tensions and fears which can easily arise in the mind of a woman alone in labor, or in a delivery room where every professional is an impersonal, masked automaton. Mothers are now getting the opportunity to cuddle and love their babies, and some fathers are no longer stopped by a cold pane of plate glass when they want to hold the new member of the family in their arms.

Leading obstetricians are beginning to recognize that routinized care, in the words of Dr. William Benbow Thompson, is "a substitute for thinking" and that "routine anesthesia must be added to the other three traditional killers of mothers—infection, toxemia, and hemorrhage."

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Much of the impetus for these changes has come from within the membership of the NOPHN Nurse Midwifery Section. If you study the proceedings of meetings of this group you will recognize that most of the changes now occurring rapidly, almost breathlessly, were spoken of and recommended in such meetings.

By whatever standards progress is measured, the nurse midwives, though few in number, have made an important contribution not only in this country but throughout the world. If progress is measured merely by a declining maternal death rate, the nurse midwives have shown the way. No better mortality record exists anywhere than in the statistics of the Frontier Nursing Service in the remote mountains of Kentucky, or of the Catholic Maternity Institute in Santa Fe, New Mexico, or of the Maternity Center Association's Nurse Midwifery Service in East Harlem, within the very shadow of a number of the world's leading hospitals.

If progress is measured in terms of satisfying service, you will find happy, contented families enjoying the experience of childbearing and the coming of their new babies where the nurse midwives serve.

You will find nurse midwives at work in hospitals, in public health departments, in visiting nurse associations, in federal and state health agencies, in the World Health Organ-

ization, in the USPHS missions to other countries, in Point Four missions to Lebanon, Iraq, and Afghanistan, in UNESCO missions, in Christian missions from Africa to Alaska. All over the world these nurse midwives are at work where new things are being done for safe, satisfying care not only for the mothers, fathers, and babies but also for the doctors and nurses.

The first school for nurse midwives in the United States was the Maternity Center Association Lobenstine School. It was organized in a typical New York brownstone house on West 113 Street, outside the walls of a university or a hospital—not by choice but of necessity. Fortunately, we had the close cooperation of two university hospitals, a medical board, and medical staff chiefly from these two hospitals. We had access to research, diagnostic, teaching, and treatment facilities, without which our work would have suffered. After twenty years of experience, however, our conviction that such a postgraduate teaching service should be within the walls of a university is stronger than ever.

This is so because education in obstetric nursing has been traditionally weak. Too little is taught all across the line about human reproduction—about what happens to a woman during pregnancy, labor, and the puerperium, emotionally as well as physically —about nutrition and posture and preparation for labor and all that great mass of information which makes the practice of maternity nursing a thoroughly exciting, rewarding, and, oh, so worth while a job. Yet the nurse is expected to put on the last bedspread or stick her nursing bag into a closet and rush into a classroom to teach parents all they need to know about getting ready to have and welcome and care for their new baby while living together happily.

Then too, nurses have not been taught enough to make them competent judges of normal labor or to enable them to recognize when things are not going right. Certain rules of thumb have been taught but no opportunity has been given them to learn to do a normal delivery under supervision. The student of basic nursing should, within the university setting, be given a very clear picture of the process of childbearing and the part played by qualified doctors and nurses and by mothers and fathers. She should be taught how to do and then do at least one or two normal deliveries under supervision. If she should be faced with an emergency she would then know more than to tie the patient's legs together and hold back the baby's head while praying for the doctor's arrival. She would have some measure of confidence and be able to transmit it to the patient. This is not enough to make her a qualified maternity nurse. In the university she could then continue her study of obstetric nursing as a clinical specialty. We are convinced that no nurse should be considered competent in obstetric nursing who has less graduate education and practice than is now included in the preparation of nurse midwives.

THE INCLUSION of this advanced maternity nursing education in a university teaching program presupposes a willingness to accept the advanced obstetric nursing student as a professional partner. It presupposes that doctors, nurses, anesthetists, technicians, and administrators have learned how to talk with one another and to listen to one another's ideas in democratic fashion, knowing that all are working upon different aspects of the same task.

In the ideal university all are learning—professors are learning, medical staff and students and interns are learning, nurses are learning, parents are learning; they are all learning together. This learning begins at the admission desk, continues through the clinics to the labor and delivery rooms, the nurseries, and to the most elaborate suite in the private pavilion. The day is coming when this postgraduate learning together of doctors and nurses will take place on a wide scale. In the meantime we must keep this nucleus of well educated nurse midwives strong and alert to every opportunity.

At the recent Fifth American Congress on Obstetrics and Gynecology in Cincinnati, before a plenary session of the nation's foremost obstetricians, Dr. Nicholson J. Eastman, professor of obstetrics at Johns Hopkins University, paid a great tribute to nurses. He

said, "The nursing profession has been the torch bearer in one of the most salutary efforts of our day, namely, the effort to reinstate childbearing as a natural function, to manage it with an understanding heart, and in so doing to make pregnancy, labor, and the puerperium a happier, more wholesome, and more emotionally rewarding experience."

Before we shut the book on this chapter and leave behind us the Nurse Midwifery Section of the NOPHN, I should like to express appreciation—and I know I speak for all of you—to the NOPHN for making it possible to create and organize and carry on the work of this section on nurse midwifery under its aegis. We recognize that there were many who looked askance at nurses adding to their title the much maligned term, "midwife." There were also those among our medical confreres who needlessly feared that nurse midwives might try to usurp medical prerogatives. These attitudes made the decision to include this specialty in a separate section of the NOPHN one which required foresight and courage. Dr. Eastman's remarks before the Obstetric Congress should make the Board of Directors of the NOPHN feel amply rewarded for having taken the leadership in this decision. Whatever the place of nurse midwifery in the new nursing structure—and there will be a place—the nurse midwife or clinical specialist in obstetric nursing—call her what you will—has come to stay and will continue to blaze the trail into the future as our partner Dr. Nicholson J. Eastman so aptly said we had been doing when he called us "the torch bearers."

Paper given at meeting of NOPHN Nurse Midwifery Section in Atlantic City, June 18, 1952.

Preparation for Labor

VERA R. KEANE, R.N.

EVER SINCE February 1951 when I became instructor to patients in obstetrics at New York Hospital we've had many visitors to our preparation for labor program. Their interests and purposes have varied widely, of course. Nevertheless, the questions they ask most commonly might be the ones you'd like to ask, too. By focusing on three such questions and outlining the answers we hope to give you a bird's-eye view of what we are doing currently.

"How do you get started on a project like this?" is the question we hear most often. And we must admit, like Topsy, that we just "growed." Parents' clearcut demands upon our obstetricians plus the doctors' professional viewpoint on the subject created a call for action, to which our administrators were quick to respond. Getting personnel ready and keeping them prepared by a strong inservice program have been important building blocks all along. Last, but not least, sound financing is vital for any undertaking, particularly for new activities in hospitals. The fact that our program is willingly supported by the community is one of its strongest points.

For classroom space a bright cheerful room was made available and converted into a minor gymnasium. Eight mattresses were arranged on the floor for use as gym mats and a small table with eight chairs and a desk for the instructor were added. From the beginning all class units were purposely organized with eight students in a group, so that informality, personal contact, and individual guidance were

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made possible. Gradually a bulletin board, teaching materials, pamphlets, and a bookshelf were accumulated. Curtains on the windows lend a cozy homelike atmosphere and our room is slowly growing into a real "relaxation" center.

Initially it was decided to begin preparing our candidates no earlier than the fourth and preferably during the fifth month of pregnancy. We still follow this plan, since it prevents including first trimester "aborters" who may think, "If I hadn't started those classes, *this* might not have happened." It takes six weeks to complete the course, so those starting at five months are finished before the seventh, when traveling and learning new physical technics become burdensome. No matter how late in pregnancy they start classes the mothers still derive some benefit from them. An early start simply allows more time for practicing relaxation, breathing control, and the exercises before the baby's birth day. Husbands and wives come together for an optional seventh session about four to six weeks before their "due" date, when a review is most meaningful.

In our earliest groups we determined the starting date of a class only after we'd had five or six requests, enough people to form a workable unit. Now because an average of twenty clinic and forty private patients file requests with us each month we have a backlog from which new groups are constantly being formed. Invitations are sent out by mail well in advance of the class starting date, in order to allow time for our prospective students either to accept or reject the appointment.

Plans for class content were originally made with the help of Maternity Center Association and remain basically the same today. Minor modifications and additions have been made largely through parents' suggestions and partly through comments from both doctors and nurses. From the beginning everyone concerned has shown great willingness to share his reactions and observations of the program in action with those doing the actual teaching. This has created a dynamic, productive atmosphere, in which we can all move forward together. Gradually we at the hospital are progressing from our remote professional plane of "I know all the answers—and I know best" to a more realistic level. We find that parents have as much to give us as we have to give them and they are eager to share, once certain of our sincere acceptance. Such a healthy attitude cannot help influencing our approach to all patients and our working relationships with all members of the professional team.

Our six classes are held weekly and although they are scheduled to last one and a half hours they often run overtime because of lively discussion or individual conferences at the end of the meetings. Sometimes parents tell us that this extension is the most meaningful part of all! We interweave exercises with factual information at each period, so that what we are doing ties in with what we are learning. For example, squatting is demonstrated when we talk about the bony pelvis and its softening joints. Familiarity with professional terms and a clear description of the probable sensations of labor seem to be the points that our parents appreciate most, next to the detailed tour of the entire maternity unit. An actual rehearsal for the big day takes up our final session, so that each mother can put together all that she has learned. Since our series includes nothing on baby care all enrollees are encouraged to attend at least part of our regular mothers' club sessions, held weekly all year round. If they avail themselves of this supplementary material we give them a diploma. Approximately eight out of ten do so, and the same proportion of husbands responds to fathers' class invitations, in addition to coming for the couples' session.

THE NEXT QUESTION we hear from visitors is "What does a fulltime instructor for patients *do* when she's not in class?" I can assure you she doesn't get bored, or find time hanging heavily on her hands! Because of the flexible framework permitted by our administration she is free to move from classroom to delivery room, from antepartal clinic to postpartal floor, and from ward to private service. In this way she is able to get maximum follow-through in her work, often shar-

ing labor and delivery with parents whom she has prepared in class. She visits every mother after delivery to hear her comments on the experience and to record statistical information on her labor. These data will eventually be used to analyze our results systematically. By circulating throughout the department the instructor sows seeds of the program far and wide. Hospitalized antepartal patients, for instance, become vocal enough to ask for instruction once they discover there is someone assigned to provide this. As a result, we now have planned periods of bedside teaching for these patients, who in general have been "left out in the cold" educationally.

Postpartal patients, too, who have not been prepared will ask questions when they see the instructor talking with alumnae of the course. The nursing and house staff feel more a part of the program when the instructor works side by side with them at the bedside. Then preparation for labor becomes not something special or set apart, but an integral element of care for all our patients.

The final and perhaps most searching question asked us is, "Just what does all this accomplish?" People who are looking for dramatically graphed statistics on length of labor, amount of medication, or conduct of delivery are usually disappointed to learn that we consider these factors of minor importance as yardsticks of success.

Our main criterion is: How do parents feel about the total childbearing experience when the job is done? If they're satisfied and feel that their efforts have been rewarded, we in turn believe we've helped a family start off on the "right foot." Certainly the parents' unity and joy in accomplishment are of far more significance than whether demerol was needed in labor. Personal interviews, questionnaires, and unsolicited letters are all used in evaluating the parents' reactions. They pull no punches and are as frank to point out our shortcomings as they are to praise our good points. Fathers especially are prolific letter writers, giving eye-opening and thought-provoking comments. The togetherness they've had in labor is mentioned more often than any other factor as a source of satisfaction to both parents.

We are, of course, keeping detailed statistical records of all labors and filing questionnaires for future analysis. By next year, perhaps, we'll have enough such information to tabulate our findings.

ANOTHER WAY of measuring our accomplishment is by the steadily increasing demand and enrollment for classes. Without any direct promotional effort the program has expanded so that three separate class groups meet four days each week. This means that an average of ninety mothers passes through our classroom doors weekly. Last year 10 percent of all our deliveries were of prepared mothers. In an obstetrical division averaging 4,000 deliveries yearly this represents close to 400 women. Surely if the program did not have value it is doubtful whether so many people would pay fees to support it and tell their friends to do likewise.

Finally, the close-knit cooperation among doctors, nurses, and hospital administrators has grown with the program. Parents are no longer associated in our minds with a little slice of care being so-and-so's province. We hear less talk of "my" patient or, worse still, "the" patient. Each mother and father is looked upon as "*our*" patient, all of us contributing a share to the total effort. This "on-the-team" feeling has been a great boost to morale for everyone, particularly the nurses. On several occasions nurses have been asked to participate at medical meetings so that greater sharing of information and ideas could be accomplished. Such support and encouragement from our obstetricians are not only gratifying but also indicate we're on the right track toward achieving a satisfying as well as a safe labor for every mother.

Paper given at the meeting of the NOPHN Nurse Midwifery Section in Atlantic City, June 18, 1952.

Trends in Patient Care in an Obstetric Service

DOROTHY E. JUMP, R.N.

THE CHANGES in policy which occur in a three-hundred-bed obstetric and gynecologic department such as we have at New York Hospital-Cornell University Medical Center are not made overnight or are they of dramatic proportions; but in reviewing the past three years we see what seems to us definite progress.

Those who heard Verda Hickcox at the Biennial Nursing Convention in San Francisco in 1950 tell of developments in the department for the period 1947-1950, or those who have read her paper* will recall that she outlined the aims which the staff hoped to achieve in the coming years. In January 1949 the first joint medical and nursing pediatric-obstetric annual conference was held. The nursing staff asked for a conference to clarify policies and medical-nursing relationships and the medical chiefs of both obstetrics and pediatrics readily agreed to it. The agenda was prepared by the nurses in obstetrics and the meeting conducted by the chief obstetrician. Two more such conferences have since been held and one of the results is a cooperative plan for newborn care.

The newborn nursery is now the responsibility of the pediatric staff. The obstetric intern and resident are available at morning rounds to discuss problems.

The mothers have an opportunity to talk with the pediatric resident after he has made an initial examination of the infants. He is available daily to discuss special problems which may arise during the hospital stay or on the day of discharge. Parents of sick or premature babies who have been transferred to pediatrics may see their infants during visiting hours; at this time a pediatrician talks to them about the care and condition of their child.

The pediatrician has a place in the outpatient parent education program also. He talks with each group of mothers enrolled in the mothers' classes and also discuss the place of the newborn in the family with the prospective fathers who meet together on five evenings.

A pediatric consultation service in the prenatal clinic was recently set up for mothers with special problems such as sibling rivalry. An effort is being made to have infants of these women registered in the Well Baby Clinic at the hospital, in order to establish continuity of care. The enrollment in this clinic is limited and usually the mothers are instructed to take their babies to a neighborhood well baby clinic.

A joint pediatric-obstetric medical staff meeting is held monthly to discuss the newborn infants. The nursing staff is invited to attend these conferences and was asked to participate in a special conference in February 1952. The theme was prenatal preparation of parents in a clinic organization.

Early ambulation and early discharge from the hospital have emphasized the need for a changing type of postpartal care. Patients are less in need of actual physical care than of instruction in self care in the hospital and upon their return home. We have revised the mimeographed sheets of information and instruction for self care in the hospital and combined them with the outpatient instruction handbook. The handbook is given to the

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* Hickcox, Verda F. Changing maternity and newborn care in the hospital. PUBLIC HEALTH NURSING, August 1950, v. 42, p. 435-439.

patient when she registers for maternity care and is used as the basis for instruction in the essentials of hygiene, nutrition, rest, and exercises in both the antepartal and postpartal periods. In addition a series of informal discussions by a pediatrician was instituted in May. She meets the mothers in small groups on the pavilion, answers questions, and makes suggestions about the care of their babies.

TWO NEW PROGRAMS, rooming-in and preparation for labor, were established in 1949 in direct response to requests from the patients. Patients on the clinic service who are interested in rooming-in are moved into a four-bed unit on the second or third postpartal day. After the mothers' breakfast the babies are brought to them for their first feeding and remain with the mothers until the last feeding in the evening, returning to the nursery only for visiting hours and for the night. The pediatrician's discharge examination is made at the mother's bedside, giving the mother an added opportunity to discuss her baby and his care with the doctor. No structural changes or new equipment were necessary to set up this service. Student nurses, after experience in the central nursery, work in rooming-in under the supervision of the graduate staff.

On the semiprivate floor a different type of plan has been in operation since late in 1951. The mother and baby are transferred directly from the delivery room to the rooming-in unit, consisting of three single rooms and one three-bed room. Here the mothers and babies are cared for by a nurse and nursing aide during the day and evening hours. The babies return to the central nursery at night to insure uninterrupted rest at night for the mothers. The evening visiting hour is reserved for fathers only, so that they may have the opportunity to learn to handle and care for their babies. During afternoon visiting hours the babies are in the central nursery.

The second new program was preparation for labor (natural childbirth) for patients attending the clinic or referred by their private obstetricians. The Maternity Center Association gave us valuable aid in starting this program, first with instruction to our supervisors and labor and delivery staff, and later in helping us establish our own classes for patients. In the beginning only those patients who came with specific requests for information were enrolled. As more patients completed the course and delivered, the demand increased. The doctors also began to refer patients who they thought had a special need for such classes.

As a large medical center in the community we felt keenly our responsibility to answer this increasing desire of prospective parents for instruction, but more and more hours of the week were being spent by the delivery room supervisor in the classroom, taking her from administrative and other teaching responsibilities. We had long recognized our responsibility for antepartal instruction for clinic patients, but never before had we been in position to assume such instruction for patients of private physicians. A joint medical-nursing-administrative meeting was held and the decision reached to charge private patients a fee of eighteen dollars for the series of seven classes. We wondered if this expense added to an already high price for obstetric care would be a burden to the prospective parents and decrease interest in the classes. The answer was soon forthcoming: we had an increase in requests for enrollment.

As new nurses joined the staff we found they were interested in preparation for labor but had little real knowledge of its purpose for the patient or of the changing role of the doctor and nurse who support the patient in labor. An inservice education program was instituted to acquaint nurses with the objectives of the program and with the actual relaxation technics which they can use to assist all patients in labor. The student nurse needed such instruction too but it was difficult to find available time in the curriculum. This problem was solved through cooperation with the physical education instructor. Four of the hours assigned to physical education are now used for teaching the exercises.

WE WERE teaching patients, graduate and student nurses; the hours each week had reached a high and the patients' requests were still coming in. There was an urgent need for a fulltime instructor for patients, but

our budget quota for supervisory personnel was exhausted. Again a joint medical-nursing-administrative meeting was held. The list of patients attending classes in 1949 and 1950 was reviewed and showed a definite increase in number in the last six months compared with the first six months of 1950. We decided that the salary of an instructor could be met by the patients' fees. In February 1951 the unique position of instructor for patients was created and the position filled. Now, in 1952, an assistant is needed.

Questionnaires were distributed to prepared patients who had had their babies. We asked for information about their reactions to their labors. Although satisfaction was expressed on almost all points, an overwhelming number said they would have wanted to have their husbands with them, particularly since they too had attended classes. This would indeed be a break with tradition! Nevertheless, the chief obstetrician gave his approval for husbands of prepared patients to be in the labor room. Even yet the obstacle was not completely hurdled; some doctors and nurses resented the presence of the husband, until they found him to be a valuable support to his wife in labor and a helpful member of the team. The prospective father who once sat out his wife's labor in the waitingroom now shares her experience and is accepted, not just tolerated by both the nursing and the medical staffs.

Almost all the steps in our progress have been made in answer to or in anticipation of specific requests from our patients. Because of them we have relaxed rigid routines which formerly separated the family unit in the hospital. The happy and satisfied mother, father, and—yes—baby too, plus the gratification afforded the hospital staff by this program seem to be the measure of its success.

Paper presented at the meeting of the NOPHN Nurse Midwifery Section in Atlantic City, June 18, 1952.

Hospital Consultation in a State Health Department Program

MARY E. FITZPATRICK, R.N.

WITH THE BUILDING of hospitals under the Hill-Burton Act we began to think how a state hospital consultation service could be made most effective. The State of Georgia has been aware that beautiful buildings do not make a hospital. That "a hospital is people" and where these people are, what they are doing, and how they are doing it are the really important features of the program.

In Georgia the building of hospitals is administered by the Division of Hospital Services, State Department of Public Health. Nursing consultation to the hospitals throughout the state was made available in January 1950 and a program to assist hospitals was inaugurated at that time.

It seemed necessary to carry out a survey of the nursing personnel available in all hospitals of the state and also to visit the hospitals to make personal contacts with those responsible for the care of patients. Unfortunately, funds were not available to undertake the kind of survey that should have been

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done, so a questionnaire for collecting the information necessary for program planning was resorted to. The survey of nursing personnel in the hospitals of Georgia was sponsored by a committee under the Georgia League of Nursing Education. The committee recognized the limitations of the questionnaire method of gathering information. However, one third of the hospitals answered and we had data from an excellent sampling of 222 hospitals in the state.

Although the results of the study of hospital personnel have not been released by the Georgia League of Nursing Education the Division of Hospital Services is in possession of the survey findings and is largely basing its consultation program on this information.

The division comprises five sections: technical, licensure, equipment, survey, and consultation. There are administrative, dietary, and nurse consultants and personnel from all sections give consultant services when necessary. A records librarian and a laboratory technical consultant will join the staff in the near future.

The unique feature of the consultation program has been a pooling of existing resources in our state to give technical assistance to hospitals which need and request it. For example, we have called upon public health consultant nurses, nursing service directors, and personnel in both private and public hospitals throughout the state to help in nursing problems. These people have been ready and willing to share their knowledge and experience with the smaller hospitals. Hospital administrators relieved nursing service directors, supervisors, and head nurses from their duties and in many instances came to meetings themselves to assist with work conferences.

The state, interested in continuing friendly relations among hospitals, is promoting a closer working relationship with the six existing state regional councils. These councils consist primarily of hospital administrators who meet in their respective regions to discuss local problems. Meetings are attended by the director and consultants of the Division of Hospital Services and assistance is given in problem solving and with program planning.

Some of the areas covered by these programs are in the fields of hospital administration, purchasing, public relations, food service, nursing service, inservice education, and training programs..

The division has promoted continued education and training for all personnel through the councils and through direct contact with personnel in the hospitals. Several suggested guides for the training of auxiliary workers have been distributed throughout the state and some form of training is carried out in about 25 percent of our hospitals.

Through working with the regional councils we are becoming personally acquainted with all types of hospital personnel. Not only the administrative but other hospital departments are beginning to have representation at the monthly meetings. As the various groups express their needs further planning is done with the councils to help meet these needs.

ASSISTANCE is given to the directors of nursing service who plan inservice staff education programs through hospital nursing committees, the educational procedure in these programs being the patient care study method. In some hospitals where this type of education is used the ward staff, the social worker, the public health nurse, the chaplain, and auxiliary help (including the orderly) describe the part they have played in the recovery of the patient.

These meetings are very informal and the discussions are lively. Coffee and cake are served before presentation of the study. Representatives from hospitals in the surrounding areas have been invited and respond fairly well.

One hospital sponsored a program on interpersonal relationships and invited the hospitals in its regional area to send staff. The mental hygiene team of the State Department of Public Health conducted this program, using the sociodrama technic. Problems were handled first as they actually occurred in the situation; then by use of the sociodrama the technic of solving problems by meeting people's emotional needs was demonstrated. Requests for more sociodramas have resulted from the demonstration.

Recently a work conference on nursing

service administration was held. The hospitals in four council areas were invited to participate. Personnel from six hospitals, both public and privately owned, and three members of the Department of Public Health assisted in the program. The forty nurses and six administrators at the conference represented thirty hospitals from the southern half of the state. The participating hospitals and the Division of Hospital Services provided a large display of related educational material and administrative tools. Most of the material distributed was donated by hospitals within the state and reprinted with their permission. One very popular number is "Personnel Policies." It has been used extensively as a guide for our smaller hospitals.

Similar work conferences have been held for hospital trustees and administrators. Several study groups have been organized in which the staff of the USPHS has cooperated with personnel from the State Department of Public Health and from hospitals within the state. Surrounding states have participated in this learning experience.

Programs which we call pre-opening conferences are held in communities where new hospitals are being erected. At such conferences, lasting two to three hours, hospital authorities, physicians, local or regional public health teams, and administrators of the new Hill-Burton hospitals review the new projects. Questions covering all phases of hospital practice—from the organization of a medical staff to training programs for auxiliary help—are discussed. Educational material for trustees, administrators, and nursing service directors is discussed and distributed. Consultants of the Hospital Services Division are responsible for the particular phases of the program which they represent.

We hope that working with these community groups is helping to develop in hospital personnel and civic groups a fuller understanding of and cooperation in the areas of professional growth and development.

One of the outstanding accomplishments of the Georgia nurses has been the publication of a guide to nursing procedures for the hospitals of the state. Representatives from more than fifty hospitals and agencies, public and private, county, state, and federal, worked together to produce this manual. The guide is written to focus attention on basic principles and to assist graduate nurses in teaching auxiliary personnel.

The consultation services sponsored by the Division of Hospital Services are democratic in concept and execution. There is no arbitrary imposition of a master plan; rather, plans are made to help hospitals with their specific problems. Educational programs in a hospital are not sufficient. The community and the hospital staff itself must realize more fully the importance and value of service. Only when educational programs foster and promote good nursing service is education serving its true purpose.

And how is it done? By a sound organizational pattern; by democratic and reasonable personnel policies which permit individual growth; by uniform interpretation of the underlying philosophy of service (and of course education for service) by supervision that thoroughly understands its role and includes broad oversight, control, direction, and adequate follow-through; and by giving nursing care designed to meet the total needs of the patient—his physical, mental, emotional, and spiritual requirements—nursing care which considers him as a member of his family and community.

We believe education is best accomplished by the application of knowledge and skills in the actual work situation. In short, the "demonstration way" is the most effective.

Paper presented at the meeting of the NOPHN Nurse Midwifery Section in Atlantic City, June 18, 1952.

Meeting Emergencies in Driving

HERBERT J. STACK, Ph.D.

STUDIES SHOW that a large number of the tragic accidents that take place each day on our streets and highways are due to the drivers' inability to meet emergency or difficult situations. The average driver is fairly skillful and fairly well informed about state and city regulations. He thinks he is a good driver, and for the most part he is, for many like him operate cars 10,000 miles a year for five or even ten years without a reportable accident. Considering the tremendous increase in the number of licensed operators (now sixty million) the great congestion on our highways, and the poor condition of many of our roads and vehicles, it is quite surprising that we do not have more accidents.

However, many of our serious accidents do not occur in ordinary, everyday driving. They result from sudden emergency situations in which the driver, often through no fault of his own, comes face to face with a situation that requires split-second thinking and split-second reaction.

This brief article is designed to show nurses how to meet some of these emergencies. It is not because they need this instruction any more than any other professional group, for the accident record of nurses is generally good, but that all drivers should know what to do in emergencies and should be able to make the right responses in difficult situations.

Whether the nurse is driving her own car or one owned by her organization, whether she is driving for business or for pleasure, it is essential that she be well informed about traffic regulations and follow the recommended safe driving practices. Because she is expected to be well informed on health practices it is quite natural that she should be an exponent of good safety practices. This would be true in driving as well as in the home and on the farm, in recreation, industry, and other areas. If the nurse is an experienced driver she should steadily strive to improve her skills and practices. As in the case of the doctor many of her missions are of such importance that they should not be interrupted by accidents. It is important that she carry at least public liability and property damage insurance on her car, at the higher limits.

On the other hand, if the nurse is just learning to drive she should seek a competent instructor. In some localities there are commercial driving schools; in others, adult training courses; in still other cases the nurse may have to depend upon a friend or relative. However, good drivers are not necessarily good instructors. In her professional preparation the nurse studies under competent teachers; if she wishes to become a really skilled driver she should learn under a qualified instructor. There are qualified instructors in almost every town and city. Many colleges give courses in driving; during the last year more than 700,000 high school students were trained in nearly 8,000 schools in the United States.

Even though the nurse in her everyday driving attempts to follow safe practices emergency situations arise altogether too frequently. What are some of the most important emergencies and how can these be met?

Skidding on a slippery curve. Nearly everyone has had this experience. The coefficient of friction on icy road surfaces or those covered with water, oil, or leaves is greatly decreased.

If your rear wheels start to skid to the right steer *in the direction of* the skid; "fan" the brakes (light applications intermittently). Don't slam on the brakes! Wheels that are turning give greater traction.

Dr. Stack is director, Center for Safety Education, New York University, and a member of the board of directors of the National Safety Council.

Obviously, most skidding can be prevented by driving slowly under slippery conditions. On snow-covered roads chains are generally helpful. When you see a slippery roadway ahead slow down and proceed cautiously.

Hydraulic brakes go bad on a hill. If this hasn't happened to you you are lucky. It's a tough experience, especially if the hill is steep.

> **Apply your handbrake, pump on the footbrake to see if pressure can be restored, shift into second gear (never into neutral) and edge your car toward the side of the road so that it can be ditched if necessary. These reactions differ somewhat with the various types of fluid-drive vehicles.**

Most hazardous situations of this kind can be eliminated by regular inspection of brakes and by starting down steep hills *in second gear.*

Tire blowout. Tire failure on the modern car is much less common than in earlier days, but when blowouts occur we have to be ready.

> **Grasp the steering wheel tightly, steer as straight as you can, "fan" the brakes (light, intermittent applications). Don't attempt to steer sharply with brakes applied. After you have come to a stop park your car off the highway.**

The best protection against tire failure is frequent inspection, proper inflation, and replacing damaged tires.

You are forced off the highway. Sometimes you are forced off by an oncoming car out of control or on the wrong side of the road. In other cases it is necessary to avoid being sideswiped by a car attempting to pass. In some instances there is a drop of several inches from the roadway to the shoulder. When your car drops off the highway there is a tendency to slam on the brakes and steer sharply back on to the highway. *Resist this impulse.*

> **Apply brakes intermittently, and when the car is slowed down or stopped shift gear and move back on to the highway. *Don't attempt to change direction sharply with brakes set.***

Obviously, even directions of this kind will vary with the conditions. At times we have to steer sharply even with brakes set, to avoid a collision with another vehicle or obstacle. No set of rules can be applied to all conditions. One has to size up the situation quickly and act accordingly.

Approaching car fails to put on passing beam. Unfortunately, this is too common an occurrence, especially in urban areas. Drivers on rural highways are usually more courteous in this respect.

> **If the driver fails to put on his passing beam (actually it is the passing beam, not the dimmers) blink your lights again. If he still fails to respond don't look directly into his lights, but rather to the right side of the roadway. Slow down if you are blinded by the glare. Glaring headlights can create a blind spot on the road ahead if your eyes are oversensitive to glare.**

Incidentally, if you want to pass a truck at night, blink your passing beam several times. Commercial drivers will respond by blinking their lights if the road is clear ahead.

The emergency stop. There are many variations of this situation. Sometimes a car, a farm vehicle, or animal comes out of a hidden road and appears suddenly in front of you. In other cases the car ahead shrieks to a stop. Here is the place where real resourcefulness or experience will pull you out of a tight spot, for there is no routine solution of the variety of complex situations. The following, however, may be helpful:

> **Apply brakes forcefully unless the roadway is slippery, when it is best to use sharp stabs on the brake pedal. If you are forced to swerve to the left at the last second, watch out for vehicles coming from the opposite direction or coming up from the rear. Sometimes it is best to pull over on to the shoulder; obviously, this depends upon conditions. If the vehicle entering the highway is at right angles take care not to swerve into its path: by the time you reach it you may be able to pass behind the vehicle. Be sure you get the habit of using your rear view mirror. Only quick thinking and the right decisions will pull you out of these altogether too common emergencies.**

In lines of traffic most motorists follow too closely. As a result, rear end collisions and sideswipes are frequent and are a major factor in increasing property damage insurance rates. A good general rule to use is to maintain a distance of at least one car length for each ten miles of speed, that is, five car lengths (roughly 160 feet) at fifty miles an hour.

Self-Rating Scale for Drivers

Draw a circle around the letter which best indicate your practices
A means always or nearly always U usually R rarely

1. Do you obey all stop signs	A	U	R
2. Do you slow down when you see children playing in the roadway	A	U	R
3. Do you pass only when the center lines show that passing is permitted	A	U	R
4. Do you treat pedestrians courteously even though they are crossing at the wrong time	A	U	R
5. Do you drive at slower speeds at night than during the day	A	U	R
6. Do you use your passing beam at night when approaching other vehicles	A	U	R
7. Do you keep a safe distance between your car and the one ahead (one car length for each ten miles an hour of speed)	A	U	R
8. Do you drive under the legal or posted speed limits	A	U	R
9. Do you use hand signals or directional signals (electrical) in indicating turns	A	U	R
10. When drivers wish to pass you do you aid them by giving them room	A	U	R
11. Do you have your car completely checked at least twice a year	A	U	R
12. Do you control your temper even when delayed by traffic congestion, accidents to other vehicles, and obstructions to traffic	A	U	R
13. Do you slow down to posted speeds in school zones	A	U	R
14. Do you stop when school buses are loading or discharging passengers	A	U	R
15. Do you abstain from drinking alcoholic liquors when you know you have to drive	A	U	R
16. When driving do you keep your eyes on the road ahead sizing up situations and using your rear view mirror for observing conditions in the rear	A	U	R
17. Do you pass other cars on the left (except in situations where it is legally permissible to pass on the right)	A	U	R
18. Do you treat other drivers courteously	A	U	R
19. Do you get in the righthand lane in preparing to make right turns *before* reaching the intersection	A	U	R
20. Do you drive cautiously at slower speeds during rain, snow, or inclement weather conditions	A	U	R
Total			

SCORING Add the total number of circles in each column. Multiply the number of *A*s by 5, *U*s by 3, and *R*s by 0. Then add to get total score. The total possible score is 100.

Scores above 90 are unusually good
80-90, good
70-80, fair
Under 60, poor; maybe you are out "looking for" an accident

You are attempting to pass and another vehicle appears suddenly in the opposite direction. There are likewise many variations in this emergency. Of course, you should not attempt to pass unless the road is clear ahead. But sometimes, even in a safe passing zone, a car comes in from a hidden road.

The best general rule is to pull back into line. Much depends on your speed, the reserve power of your car, and how nearly the passing maneuver is completed. But watch out for cutting in too quickly. Remember that to pass another car you must drive at least ten miles an hour faster. Thus, attempting to pass when going at high speed on a two-lane road may involve real risks. Most state laws require passing on the left. Moreover, at least on main roads, most states have center lines indicating when it is safe to pass. These lines have been established by engineers who study the situation carefully; rely on their judgment rather than taking chances.

WE HAVE attempted to present a few of the most serious emergencies—serious

(Continued on page 519)

A Health Department Develops a Generalized Public Health Nursing Service

JOHANNA E. KENNEDY, R.N.

JUST A YEAR AGO the Public Health Nursing Service of Union City, offering a generalized program as part of the Union City Health Department, was established. When the health officials and other interested citizens first began to consider setting up this program they were asked, "Why not organize a vna?" The community's earlier experience with a vna had not been successful. An agency sponsored by the American Red Cross and the Kiwanis Club a number of years before had failed, most probably because of lack of community support. Another question asked was, "Why not organize a combination service?" This one was easy to answer: There was nothing to combine!

The only bedside nursing services in 1949 in Union City were the programs maintained by the insurance companies, the Metropolitan and the John Hancock. The latter company employed only a parttime nurse. Union City is a landlocked congested municipality of 56,000 people. The residents, mostly of Italian origin, work in industries in adjacent communities and in New York, which can be reached by bus in fifteen minutes. They are interested in political activities but it is difficult to get support for community services. For instance, there is no community chest in Union City or in neighboring areas and the only family service agency is the Catholic Charities. On a county basis there are several active voluntary organizations: Hudson County Tuberculosis and Health League, Salvation Army, Hudson County Cancer Society, and the Hudson County Council of Social Agencies.

At that time the Health Department staff was composed of a parttime health officer, three sanitary inspectors, and two public health nurses assigned to the parochial schools.

A well baby service was carried on in a building erected for that sole purpose. Clinics were held four afternoons a week. The clinics were staffed by a parttime physician, three graduate nurses, and two practical nurses, but no follow-up home visits were made. A neighboring community paid $1,000 annually for service to its infants.

Venereal disease work—clinic and follow-up—was done by one worker for the entire North Hudson area. Union City paid for this service. The North Hudson Chest Clinic, an extension of the county tuberculosis service, was responsible for the tuberculosis activities. Two nurses maintained this clinic and did some home visiting. School nursing in the public schools was administered by the Board of Education. A psychiatric social worker from the State Mental Hygiene Clinic and an orthopedic advisory nurse from the State Health Department were available for consultation.

A new health officer came to Union City in 1950. During the war he had been assigned to a post in Texas and there had seen a group of people work together cooperatively for the kinds of health services they wanted for their families. He felt people in any community could do the same thing. Therefore, when the local MLI supervisor discussed the need for a generalized public health nursing program for all the residents of the city she found him receptive to the idea. As a county health survey was under way it seemed best to wait for the survey findings and recommendations before starting new activities.

Another year went by before the subject came up again. The commissioner of public affairs and the health officer were being be-

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sieged with requests for bedside nursing service. The city had no hospital and the Welfare Department's bills for hospitalization of the medically indigent amounted to about $80,000 annually. The health officer had enlisted the support of the commissioner, who was most interested in the project, and an appropriation of $12,000 had been made to start a nursing service under the auspices of the Health Department.

At the suggestion of the MLI supervisor the health officer sought advice from the NOPHN. A consultant from headquarters visited Union City, analyzed the situation, and made recommendations for proceeding. She advised that a citizens advisory committee be set up, but this needed more local consideration before official sanction could be obtained. Meanwhile the MLI supervisor worked closely with the group interested in establishing the nursing service. She was able to secure a good deal of assistance from the administrative staff in the MLI Nursing Bureau. Throughout the project the MLI's role was one of submerged leadership. The company sought no publicity but at all times was available to give help as needed, leaving final decisions to the local authorities.

EVERYONE AGREED that a clean sweep could not be made, that there were certain compromises to be accepted. For example, it seemed desirable to continue the well baby service without change. The decision was made mainly because this program was near and dear to the hearts of the residents and any interference with it might have affected the new plan adversely.

A tentative budget was worked out and a program of primary needs outlined. Coverage of the five parochial schools must be continued and bedside nursing care for the sick at home made available. Other programs such as communicable disease control and maternal health could, to some extent, be woven into the morbidity program. As soon as these services were going smoothly the VD and TB programs were to be added. Since the emphasis was to be on family health, with one nurse supplying all the nursing service a family might need, health education was considered an integral part of all the service activities.

The two nurses already on the Health Department staff were interested in the proposed nursing service and agreed to remain on the staff. The plans called for five field nurses, a supervisor, and a fulltime clerk. Each nurse was to be responsible for all nursing care, including service in the parochial schools, in her assigned district. Salary ranges and personnel policies were to be equalized for all the nurses.

During this period of planning the health officer and commissioner of public affairs visited Montclair where there is an effective combination public health nursing service. The Montclair personnel were most generous with their time and advice. Again the importance of a citizens advisory committee was stressed and the warning given that a good program could not be set up in a hurry, but needed careful planning.

The NOPHN consultant had recommended that a meeting be planned to which all interested in the proposed program be invited. This meeting was held and a representative from the state joined the local people. Everyone agreed that the nursing organization must be kept free from politics and that a well prepared supervisor, meeting NOPHN recommended qualifications, should be employed.

The state nursing representative at the meeting stated that financial aid was available to local communities starting nursing services and she explained how to make a request for a state grant-in-aid. The MLI supervisor suggested that the MLI might lend one or two qualified nurses to help start the program and she too advised how such a request could be initiated.

The ordinance, necessary to give legal status to the new service, was drawn up by the city counsel with the guidance of the health officer and was passed without difficulty in June 1951. In this way the Public Health Nursing Service of Union City was created. The ordinance provided for a citizens advisory committee, a medical advisory committee, and the appointment of three public health nurses; it also created the position of supervisor. Salary ranges were established and personnel policies, following NOPHN standards in gen-

eral, were set. Provision for fee collection was incorporated in the ordinance.

The community reaction was most favorable. Everyone seemed happy about it—families, doctors, and city officials. Reporters from local newspapers had attended most of the planning meetings and had kept the people informed about what was going on. The papers made it clear that the city's hospitalization costs were extremely high and that the nursing service would help to cut these costs. It was also made clear that this was not the main purpose of the service—there was a very real need for a public health nursing program in the community.

Most fortunately a local nurse with proper qualifications was interested and available and she was appointed as supervisor. Since all her previous experience had been in voluntary organizations arrangements were made for her to spend four weeks at the Montclair Bureau of Public Health Nursing.

It was then time to think about an office and equipment. A group of local people visited other nursing centers—Mamaroneck, Rye, Greenburgh, Dobbs Ferry, Pleasantville, and Tuckahoe, all in Westchester County, New York—and saw a variety of offices. The advantages and disadvantages of offices in stores, office buildings, health centers, were weighed and the decision arrived at to rent space in the Union City MLI office temporarily until the health center the city contemplated building was ready. The nurses' advice and suggestions about their needs were to be incorporated by the architect into his plans.

During the summer the health officer made plans for the appointment of the medical advisory committee. Representative citizens from many community groups were invited to become members of the citizens advisory committee. Their response was most gratifying. Tentative plans made along the way worked out well. The MLI assigned two nurses, two were already on the Health Department payroll, and the state grant-in-aid was available for employing a fifth nurse. The office was attractive with equipment provided by the MLI. The community wanted the service—the calls were coming in. We knew there most probably would be some rough spots, some stormy days, but we were ready.

Today, almost a year later, we have many indications that our program is succeeding. Our community is enthusiastic, our citizens committee active. Four neighboring communities, without nursing services, are exceedingly interested in what is going on in Union City. The mayor of one has asked our supervising nurse, and also the State Health Department, for suggestions about setting up a similar service. Physicians in these communities want public health nursing care for their patients too.

It was a thrilling experience to participate in the development of this program. No progress could have been made without the wholehearted cooperation of the many groups and organizations, which gave generously of their time and counsel. From the earliest days the health officer and commissioner of public affairs provided leadership to the other city officials and stimulated interest in the development of the project. In fact for the commissioner of public affairs it was a dream fulfilled.

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Stipends Offered in Psychiatric and Mental Health Nursing Programs

ADVANCED preparation in psychiatric and mental health nursing is being sought by nurses in steadily increasing numbers. A total of 192 nurses received USPHS stipend awards in 1951-1952 for study offered in twenty-three university programs. Under the terms of the National Mental Health Act stipends ranging from $1,600 to $2,400 have been awarded each year since 1947 to students in various programs on the basis of need and scholarship.

During the 1952-1953 academic year programs in advanced psychiatric nursing will be offered by the schools listed below.

Boston University School of Nursing, Boston 15, Massachusetts
University of California School of Nursing, San Francisco 22, California
Catholic University of America School of Nursing Education, Washington 17, D. C.
University of Cincinnati College of Nursing and Health, Cincinnati, Ohio
University of Colorado School of Nursing, Denver, Colorado
Columbia University Teachers College Division of Nursing Education, New York 27, New York
University of Connecticut School of Nursing, Storrs, Connecticut
Duke University School of Nursing, Durham, North Carolina
Indiana University School of Nursing, Bloomington, Indiana
State University of Iowa School of Nursing, Iowa City, Iowa
Louisiana State University Department of Nursing Education, New Orleans 13, Louisiana
University of Minnesota School of Nursing, Minneapolis 14, Minnesota
University of Pennsylvania Department of Nursing Education, Philadelphia 4, Pennsylvania
University of Pittsburgh School of Nursing, Pittsburgh, Pennsylvania
University of Rochester Department of Nursing Education, Rochester, New York
University of Tennessee School of Nursing, Memphis, Tennessee
University of Texas School of Nursing, Galveston, Texas
Washington University School of Nursing, St. Louis 10, Missouri
University of Washington School of Nursing, Seattle 5, Washington
Wayne University College of Nursing, Detroit, Michigan
Yale University School of Nursing, New Haven, Connecticut

Schools which offer mental health nursing programs

Catholic University of America School of Nursing Education, Washington 17, D. C.
Columbia University Teachers College Division of Nursing Education, New York 27, New York
Johns Hopkins University School of Hygiene and Public Health, Baltimore 5, Maryland
University of Minnesota, School of Public Health, Minneapolis 14, Minnesota
University of Washington School of Nursing, Seattle, Washington
Yale University School of Nursing, New Haven, Connecticut

Application for admission to any of these programs and for stipends should be made directly to the school chosen by the individual.

Further information about psychiatric and mental health nursing may be obtained by writing to Miss Kathleen Black, psychiatric nursing consultant, National League for Nursing, 2 Park Avenue, New York 16, New York.

Working Relationships between Public Health and Extension Services in Rural Areas

DORIS PEEPLES, R.N.

THE ever-broadening concept of health necessitates close working relationships between community agencies. In rural areas this is especially important where public health and extension service personnel often find themselves working side by side. Sound working relations come with a thorough knowledge of the program, objectives, and limitations of each other's agency.

The public health worker's primary objectives are the promotion of health and the prevention of disease. He realizes that he cannot ignore such contributing factors to health as housing, food supply, nutrition, source of income, and general economic well-being. The extension worker's primary objectives are the increase of farm production, the improvement of the farm family's economic status, and the development of an appreciation of farm life. He realizes that without optimum health the family cannot develop a happy and satisfying manner of living or utilize to the fullest the resources of the farm and community. Both groups of workers must have a thorough knowledge and appreciation of the socioeconomic problems and needs of the community. Their programs must be built around these problems and needs.

In a broad check of the agricultural areas of southeastern United States or of any agricultural area we immediately see that the section specializes in one crop because of the soil, climate, and general conditions. It is a major money crop, usually called a subsistence insurance crop. Such highly specialized conditions develop a strong resistance to change. The hazards confronting a farmer in changing his subsistence insurance from one crop to another are the same as those that would confront a doctor or lawyer asked to change his specialty. Such changes in occupation are not usually made unless forced upon the individual by emergency conditions.

Let's look at Suwannee County in Florida and see how the health problems relate to the farming situation and how the extension worker and public health personnel work together for the improved welfare of the rural family. The general character of Suwannee is of a rolling, sandy, pineland nature. The soils were originally covered with heavy growths of longleaf pine which have been logged to a high degree. The logging operation completed, the farms were developed and in the main were planted in longstaple cotton. Bright tobacco later became the major crop. The production and preparation for market and sale of tobacco require hard labor and vigilant attention. The peaking of labor demands during the harvesting and curing period sets to a large extent the agriculture pattern of the county. Plans for all crops are made with the underlying assumption that there must be sufficient labor available on the farm during tobacco harvesting and curing. Every farmer, from the day he plants his seedbed in January through the sale of the crop at the August auction, plans, arranges, trades, and uses all efforts to arrive at agreements with his friends and neighbors to assure the necessary labor for this period. Labor is swapped, traded for seedplants, use of equipment, borrowed, and at times even hired.

Tobacco growing influences the entire life of the community. Merchants carry the farmer's accounts until the sale of his crops. Banks

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and stores remain open until the end of the sales of the day. The housewife rents the extra bedroom to the tobacco auctioneers, workers, and government inspectors. Women and children help with the cropping and stringing of the leaves in preparation for the curing process. And yet the average family income is $1,765 a year.

The extension workers have been teaching the value of a more diversified type of farming and slowly changes are being made. Livestock production, permanent pastures, and produce and food conservation are becoming more meaningful to Suwannee County's farm families. The health challenges are poor nutrition, dental caries, tuberculosis, and a high prematurity rate. The soil is also conducive to hookworm growth.

The Suwannee County Health Department is housed in the County Agricultural Building, which makes the agencies easily available to each other. Many of the facilities designed originally for the home demonstration agent, such as a demonstration kitchen, a conference room, and so on, are also used by the health personnel.

The extension worker helps interpret the health department program to the community just as the health worker interprets the extension services. The public health nurse encourages the families she visits to become club members. She knows how their lives will be enriched and broadened by the varied educational programs sponsored by the extension service. The club activities are carried out largely by the project method of learning. Health projects are highlighted in both the adult and 4H clubs. The very name 4H typifies the training of head, heart, hands, and health which the club program provides.

These organized clubs, of course, can do much to promote the public health worker's program. They can be a medium for disseminating health information to the more remote rural areas which are less likely to be reached through the newspaper and radio. In this section the extension service is older than the organized health service and the club groups do much to interpret the health department's program in the community.

The public health nurse meets with the clubs periodically to discuss various phases of health and to show health films. Home demonstration clubs can be used for such community activities as mass x-raying, hookworm surveys, and other group health programs. This group also can serve as volunteer clerical help for these surveys and for drives such as

the Christmas seal sale. The proverbial county fair, sponsored by the extension service, gives the health workers an opportunity to display health exhibits and schedule health films.

The nurse and extension worker share materials for programs and projects. Occasionally both workers make home visits together, particularly when nutrition is a major problem. The home demonstration worker plans an individual family food budget and the nurse discusses nutrition in relation to health. Both workers stress the importance of a year-round garden, and the extension worker teaches the family how to preserve surplus by canning or freezing. If a nutritionist is not available the nurse may use the services of a home demonstration agent in mothers' classes and in well baby clinics.

IN THE FALL of 1951 a study to learn some of the food habits of school children was undertaken. Both the health and extension workers are directing their joint efforts to health education areas where the study findings indicate needs.

We found that all the children were eating plenty of breads, cereals, and other starchy foods, but these were the only basic foods they got in proper amounts. However, since Florida does not have an enrichment law and many of the foods the children ate were rice and grits there was room for improvement. We have been trying to make people more aware of the value of enriched breads and cereal products and encouraging them to ask for such products.

We found the children did poorest in our farm-produced foods: milk, green and yellow vegetables, citrus fruits, tomatoes, and raw cabbage. Less than 20 percent of the children were eating the recommended amount of any of these foods each day. And only about 40 percent of the children ate enough of the other fruits and vegetables, potatoes, and eggs daily.

In Suwannee County we are fortunate that home gardens can be productive all year round. Of course the soil must be prepared and regular attention given to the gardens. In one of our communities a 4H school garden was started by the extension workers and the produce used in the school lunchroom. The club plans to add a pig to the project soon.

An animal feeding experiment is another school activity that the health department has helped to carry out. This has proved to be a very interesting project for both the children and the community. Parents tell us that their children now ask for breakfast, instead of being forced to eat before they rush off to school. But this story is told more effectively by one of the third graders himself.

"The health department gave us two white mice. We got the mice November 8, when they were four weeks old. We named them Pinky and Stinky. Pinky is larger than Stinky because we fed Pinky good food and Stinky poor food. Pinky was fed cheese, milk, vegetables, fruit, bread, and butter. Stinky was fed bread, jelly, candy, and soft drinks. We're feeding them to see the difference between good food and poor food. Pinky weighs more than Stinky weighs. This shows us that boys and girls need good food to grow and keep healthy."

For many years the teachers have made a practice of measuring each child's height and weight some time during the school year. These measurements are entered on the school health record. Realizing that routine taking of measurements does not necessarily show their significance the teachers have started to keep a graph on each child. By plotting the child's past, present, and projected growth pattern using the Wetzel Grid* we have a better chance of bringing attention to unusual features in a child's build or in his progress. We find there is a rapid shift in the growth pattern of second grade children and we are convinced that much can be learned by concentrating our efforts on this age group. Of the first 95 children studied 71, or 72 percent, showed a decelerated growth pattern from the time they entered the first grade. When these children were home all day did they eat better? Now, when they are away from home most of the day, their breakfasts and evening meals become increasingly important. Yet the

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* Reekie, Dudley A. The Wetzel Grid. PUBLIC HEALTH NURSING, April 1951, v. 43, p. 216-218.

health study showed that 21.6 percent of the children were eating very little or no breakfasts and the evening meal was found to be the poorest of the day; 40.8 percent of the children said they ate very little or nothing (as a meal) after they returned home from school.

The above situations are not necessarily caused by lack of income. In one school of more than five hundred children each child spent an average of seven cents daily for sweets and soft drinks. We think, rather, that the situation presents a challenge for community health education; we think we can shift our emphases in health teaching so that definite improvement in nutrition will take place.

These examples of close cooperation between rural public health and extension workers have largely referred to the public health nurse and the county home demonstration agent. However, these relationships exist also between other personnel of both agencies —for example, the farm agent and the sanitarian. The importance of such close working relationships cannot be overemphasized as a factor in the effective progress of both agencies.

Emergencies in Driving

(Continued from page 511)

because errors in judgment and reaction can end in disaster. There are many others that cannot be discussed in this brief article. We must know what to do and have prepared decisions ready when we meet the emergencies. These situations for the most part are caused by bad practices, violations, and poor attitudes of the motoring public. It is interesting to note that in most of the fatal traffic accidents in our country last year (which resulted in 37,500 deaths) the driver was at fault, committing some violation in a vast majority of the cases. Defective highway conditions and unsafe vehicles contributed to but 15 percent of the accidents. Traffic accidents are caused chiefly by unsafe acts of drivers and pedestrians. They resulted in over 1.7 million nonfatal injuries last year. The overcrowding of our hospitals is due materially to this large number of accidents. Studies at the New York University Center for Safety Education* indicate that the underlying causes of these unsafe acts are faulty attitudes, ignorance of safe practices, emotional instability, and personality maladjustment. We contend, therefore, that while improved engineering and enforcement are of value the chief force in our attack on traffic accidents is going to be through education and improved driver's license regulations. There is a responsibility for all of us to improve our driving practices. The next few years will undoubtedly bring on more congestion of traffic. The best answer to the problem of the terrific toll of accidents and mounting insurance rates is better driving.

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* *The Motor-Vehicle Driver: His Nature and Improvement.* Prepared under a grant from the Eno Foundation for Highway Traffic Control and distributed by the Center for Safety Education, New York University, New York. 165 pp.

Case History of a Nurse's Case

HAZEL HIGBEE GIBBS, R.N., and GLADYS GIRTON, R.N.

THE PUBLIC health nurses in the Virginia State Department of Health carry their patients' records on Kardex forms into the homes with them. Until recently the records were carried in a case and often when a nurse was loaded down with her nursing bag, her handbag, and possibly an umbrella and a few other items, the record case was left behind.

The solution seemed obvious to us: get one bag large enough and of the proper shape to hold all the necessary nursing equipment as well as the records. About a year ago we began to investigate sample bags. There wasn't a bag on the market that answered our needs!

One day we mentioned the situation to the Remington Rand representative. We asked him, "Why couldn't the Book Kardex be made a little larger with a fitted nurse's bag on one side and the whole thing have a zipper closing like a briefcase?"

The representative could think of no reason why this couldn't be done and said his firm would undertake to produce exactly what we had in mind. Then followed discussions, drawings, and models—and finally the finished case, exactly as we had visualized it.

Our new bag looks like a well filled zipper briefcase. It is compact and easy to carry under any circumstances. The nurse doesn't have to carry an additional notebook, as reference information such as physicians' telephone numbers, clinic hours, et cetera, can be put on cards in the Kardex pockets.

When the zipper is opened one side of the case contains a complete panel of Kardex pockets in which the individual cards are placed. Behind this is a large pocket where family history folders, pamphlets, and other material can be kept. The other side is a rectangular, rigid, snap-opening fitted leather nurse's bag insert with adequate supplies, in easily accessible compartments, for a generalized public health nursing service. There is a place for everything and in addition the nurse can also fit in pencils, a cosmetic case, and a change purse.

It is no surprise that the nurses are enthusiastic about their new bags, as many of them had offered suggestions for designing the bag. We feel we have overcome an insurmountable obstacle by the simple process of removing it. The cost of the new bags is completely warranted by their usefulness and by the additional effectiveness they give our program.

The Kardex System

The Virginia program is based on complete records in the local units. These are main-

Mrs. Gibbs is director, Bureau of Public Health Nursing, Virginia Department of Health. Miss Girton is state advisory nurse.

tained on Kardex forms which we have designed and perfected to our satisfaction over a number of years.

The special advantage of the Kardex system is that every case is visibly indexed by name, identified as to type by color, and signaled for date of last call. One small cabinet in the local unit contains all of its records, yet any group can be identified and summarized as necessary. When families move from one area to another the uniform record fits into the equipment of the new local area.

The public health nurses plan their calls by consulting the Kardex and removing the case history of each family to be seen. A "title insert" remains in the pocket of the office cabinet to identify the record that has been removed. The nurse inserts the cards in pockets of the Kardex panel in her new case, arranging them in rotation of call. The visible margins indicate every case, making it almost impossible to overlook a call en route.

When the nurse selects the Kardex records she also removes the proper family history folders from the vertical file and takes them along.

Most of our nurses report in daily and take only the cards required for one day. There are enough pockets, however, so that records for several days can be carried. Proper notations are made on the record at the time of the call. The cards are returned to the local office daily, and reinserted in the office cabinet by a clerk who at the same time resets the visible signal indicating date of last call. The color of this signal also tells whether the case is normal (green) or whether there are complications (red)—thus visually indicating the need for more frequent attention.

We have worked twelve years on developing Kardex records to their present completeness. The local unit has a constant and comprehensive picture of its caseload and activity; the nurse in the field makes her calls with the actual record, on which additional notations are immediately placed.

And this sound theory is now constant practice, thanks to our new bags.

Work Conferences

(Continued from page 487)

education and experience were represented, ranging from that of a college dean down to [or perhaps it was up to, as it really was "her day"] the student herself. It was my first such experience and one I shall not soon forget.

"My first impression was of the friendly, interested spirit prevailing, from first to last. This was not a planned program of events with me as a lesser spectator; this was alive and charged with a kind of excitement rarely found in nursing circles. We were on a first name basis with almost everyone, and our place cards at dinner the first night kept us from those deadly cliques with which we are all so familiar. The idea of eating with someone new each meal provided interesting topics, which didn't sound at all like shoptalk. After the last meetings of the day broke up some of us drifted away for a cold drink or a cup of coffee, with the discussions still lively at midnight.

"It was interesting to note that at the end of a two-hour buzz session we were just warming up to the subject and feeling each other out. We worked hard, but I enjoyed it."

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NEWS AND VIEWS

FROM HEADQUARTERS

NLN STAFF

At the first meeting of the National League for Nursing in Atlantic City Ruth Sleeper, president, announced the appointment of Anna Fillmore, R.N., as general director of NLN. Since then other appointments have been announced. Julia M. Miller, R.N., formerly executive director, NLNE, has been appointed director, Division of Nursing Education, NLN, and Marion W. Sheahan, R.N., director of programs, National Committee for the Improvement of Nursing Services, has been appointed director, Division of Nursing Services, NLN.

Ruth Fisher, R.N., has been named director of the Department of Public Health Nursing which will carry on, with other activities, the program of NOPHN. Miss Fisher was formerly associate director, NOPHN. Kathryn W. Cafferty, R.N., formerly director of the Department of Services to Schools of Nursing, NLNE, is now director, Department of Diploma and Associate Degree Programs. Helen Nahm, R.N., has been appointed director of the Department of Baccalaureate and Higher Degree Programs. Miss Nahm was director, National Nursing Accrediting Service, and in her new position will direct the NLN program for accreditation of educational programs in nursing. The director of the Department of Hospital Nursing has not yet been named.

Other staff appointments include Mrs. Marjory B. Hyde, director of Membership Unit; Walter W. Dix, director of Business Services; Mrs. Muriel C. Henry, director of program, Committee on Careers in Nursing; Ruth Bishop, director of Evaluation and Guidance Service, which provides testing services to licensing authorities and schools of nursing to aid them in the selection and evaluation of students; Mrs. Edith Wensley, director of Public Relations.

Louise M. Suchomel, R.N., is senior consultant, Advisory Nursing Service for Poliomyelitis and Orthopedics (formerly JONAS); Jean South, R.N., is senior consultant, Tuberculosis Advisory Nursing Service (TANS, formerly JTNAS); and Kathleen Black, R.N., has been appointed director, Mental Health and Psychiatric Nursing Project. Formerly Miss Black was assistant professor at the University of Minnesota School of Nursing (1950-1951) where she established courses in psychiatric nursing on the master's level. Earlier she was director of nursing education, Menninger Foundation; instructor in advanced psychiatric nursing, Teachers College, Columbia University; head nurse, University of Chicago Clinics and Cook County Psychopathic Hospital; instructor, psychiatric nursing, the Sheppard and Enoch Pratt Hospital, Towson, Maryland. In the 1930s she was an instructor and supervisor in several Canadian hospitals.

Miss Black is a graduate of Ontario Hospital School of Nursing, Whitby, Canada. She attended the University of Toronto and holds a B.S. degree from the University of Chicago and an M.S. from Teachers College, Columbia University.

NEW FOUNDATION FOR COMMUNITY HEALTH

Formation of a new foundation in the field of community health was recently announced by the president of the Cunningham Drug Stores, Incorporated. The Cunningham Drug Company Foundation will devote its resources to aiding the nursing profession, improving medical and hospital care, and promoting research into the cause, treatment, and cure of diseases.

The foundation has appointed Mrs. Mary Kelly Mullane, formerly associate professor

of nursing at Wayne University and assistant to the dean of the College of Nursing, as director of nursing. She will be responsible for the planning and carrying out of the foundation's program as it relates to nursing. The first project is nurse recruitment. The foundation staff will work closely with existing agencies in the campaign to recruit students for basic professional schools of nursing and for schools of practical nursing.

Mr. Mark Neal Beach, executive director of the Greater Detroit Hospital Fund since 1948, is director of the new foundation.

PUBLICATIONS AVAILABLE

Single copies of A Healthy Personality for Your Child are available free of charge from the Children's Bureau, Federal Security Agency, Washington 25, D. C., as long as the supply lasts. This twenty-three page booklet is a popular version of part of the Fact Finding Report prepared for the Midcentury White House Conference on Children and Youth. This report is written primarily for parents and attempts to give them an understanding of the stages through which children grow emotionally from infancy to adulthood.

A series of articles on medical aspects of civil defense from the *Journal of the American Medical Association* has been put together and may be purchased from the AMA, 535 North Dearborn Street, Chicago 10. A single copy of Medical Aspects of Civil Defense is 25 cents.

The National Foundation for Infantile Paralysis has prepared two new pamphlets which all nurses will find helpful: Management of Poliomyelitis Patients with Respiratory Difficulty and Isolation Techniques and Nursing Care in Poliomyelitis. Copies available from NFIP, 120 Broadway, New York 5.

The American Hearing Society is distributing reprints of Recent Developments in Hearing Aids by S. R. Silverman and R. W. Benson. The original article appeared in *Hearing News*, May 1952. For copies write to 817 14 Street, N.W., Washington 5, D. C.

Bladder and Bowel Training Program for Patients with Spinal Cord Disease has been published as a monograph by the New York University Institute of Physical Medicine and Rehabilitation, 400 East 34 Street, New York 16. A filmstrip for lectures is also available. Price of monograph 40 cents.

TOXOPLASMOSIS

The Public Health Service has released a report, Toxoplasmosis, on this usually unrecognized disease, the cause of an acute infection in the newborn which is generally fatal. The causative agency is commonly thought to be a protozoal organism. The exact mode of transmission of the disease has not been definitely determined but arthropod transmission has been suspected.

An acute infection may produce symptomatic visceral and central system lesions in fetuses, infants, and at times in children and adults. Apparently the infection is unnoticed in adults and in many children, who have relatively high resistance. The acute stage may subside when neutralizing antibodies develop but subacute and chronic infections may follow, especially in the central nervous system and the eye, and toxoplasma cysts may remain in the heart and skeletal muscles, the latter condition resulting in a carrier state.

Diagnosis of the disease has been quite accurate wherever the organism has been isolated or where it has been identified at autopsy, but isolation has frequently not been possible. Fetal infection with some of the viral diseases such as measles, mumps, and poliomyelitis may lead to malformations simulating toxoplasmosis, but these diseases usually affect the fetus in an earlier stage of pregnancy than toxoplasmosis. If the pregnant woman has acute toxoplasmosis in the first trimester she aborts in most cases.

The acute stage in animals is controlled by sulfadiazine and sulfamerazine in full doses, but some of the newer drugs, such as streptomycin, chloromycetin, and penicillin, are ineffective, although aureomycin and terramycin are slightly effective. The carrier state is not eradicated by any of the drugs. Previous delivery of a toxoplasmic infant by a mother or serologic evidence of past or persistent infection is not an indication for treatment in a future pregnancy. None of the mothers with clinical or serologic evidence of having had

the disease subsequently gave birth to infected infants. If the diagnosis of the disease in the woman is made late in pregnancy treatment with sulfadiazine-sulfamerazine mixtures may be instituted to suppress probable infection in the infant.

It is likely that most adults in the United States may become infected with the disease once in their lifetime, but this is generally unrecognized and unrecorded because symptoms of the infection are slight.

Copies of the report may be obtained from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Price 50 cents.

NOPHN FIELD SCHEDULE—AUGUST

Public Health Nursing Staff

Hedwig Cohen	Silver Bay, N. Y.
Margaret Leddy	Woodbridge, N. J.
Louise M. Suchomel	State College, Pa.
Judith E. Wallin	Jackson, Mich.
	Dubuque, Iowa
	Cedar Rapids, Iowa
	Clinton, Iowa
	Muscatine, Iowa
	Des Moines, Iowa

July field trips not previously reported: Marjorie L. Adams, Belmont, Salem, Chicopee, and Greenfield, Mass.; Judith E. Wallin, Maywood, Ill.; Frances E. Goodman, Houston, Tex.: Helen S. Hartigan, Houston, Corpus Christi, and Harlingen, Tex.; Louise M. Suchomel, Houston and Harlingen, Tex., and Sioux City, Iowa.

PREPARING TOMORROW'S NURSES

The Public Affairs Committee working in cooperation with the National League for Nursing has just published Preparing Tomorrow's Nurses. This pamphlet describes in nontechnical language the increasing scope and complexity of nursing care and the education nurses need to give this care. It will be especially valuable in helping nurses to interpret nursing and the aims and problems of nursing education to citizen groups.

The pamphlet was written by Elizabeth Ogg and may be purchased from the National League for Nursing, 2 Park Avenue, New York 16, New York. Price: 1-9 copies, 25 cents each; 10-99 copies, 18 cents each. Prices on larger quantities quoted on request.

ABOUT PEOPLE YOU KNOW

Hazel Shortal, who has been chief nurse consultant, Division of Venereal Disease, USPHS, has been appointed public health nursing consultant with the Institute of Inter-American Affairs. Miss Shortal will serve parttime in the Washington office as assistant to Kathleen M. Logan, chief nurse, Division of Health, Welfare, and Housing, IIAA, and parttime in the countries of Latin America in which this division has programs. . . . *E. Alice Clark* succeeds Miss Shortal as chief nurse consultant in the Division of Venereal Disease. She will work with state health departments, universities, and professional groups. . . . The Institute of Inter-American Affairs also announces the appointments of *Mrs. Anne Rutherford* as public health consultant in San Jose, Costa Rica, and *Barbara Hennigan* as consultant in nursing education in Paraguay. Mrs. Rutherford recently was student health counselor at Incarnate Word College, San Antonio, Texas. For the past five years Miss Hennigan has been on the staff of Children's Hospital, Buffalo, New York.

Mary A. Coleman, executive director, VNA of Staten Island, retired in July. The board has appointed *Mrs. Marian B. Nelson* as acting executive director. . . . *Mrs. Myrtle Spencer* is the new director of the Ridgewood Nursing Service in New Jersey. . . . *Margaret L. Shetland,* chairman, Department of Public Health Nursing, State University College of Medicine at Syracuse, has been named secretary of the New York State Citizen Health Council.

Ellen Buell, professor of public health nursing and director of the programs in public health nursing at the Frances Payne Bolton School of Nursing, Western Reserve University, since 1943, retired at the end of the summer session. Prior to joining the faculty of Western Reserve University Miss Buell was director of the Department of Public Health Nursing, Syracuse University. She had also been associated with Henry Street Visiting Nurse Service and the Department of Health in Utica, New York. Miss Buell has been closely associated with NOPHN activities through her membership in the Collegiate Council on Public Health Nursing Education and has contributed to the literature of public health nursing. . . . *Esther Leihgeber,* associate professor of public health nursing, will act as chairman of the public health nursing faculty at Western Reserve until an appointment to the position is made.

NEW BOOKS
And Other Publications

PSYCHOSOMATIC GYNECOLOGY INCLUDING PROBLEMS OF OBSTETRICAL CARE

William S. Kroger, M.D., and S. Charles Freed, M.D. Philadelphia, W. B. Saunders Company. 1951. 503 p. $8.

This is an attempt by a gynecologist, Dr. Kroger, and an endocrinologist, Dr. Freed, to survey our present knowledge of the interaction of mind and body in female disorders and to stress the importance of emotional factors in the etiology of gynecological conditions. A special chapter on the psychosomatic aspects of pregnancy has been contributed by Dr. Grantly Dick Read. This is essentially a brief presentation of his views on natural childbirth.

The volume as a whole is a compendium of information on the subject. There are more than a thousand direct references as well as other references for further reading.

Part 1 is concerned with the prenatal and postnatal period and with the genesis of later gynecological disorders. This leans heavily on Freudian psychoanalytic theory and is therefore speculative and controversial. However, an even more speculative discussion is that on the modification of inherited characteristics by fetal environment. This attempt to understand the extent and importance of prenatal influences in determining the physical condition, the emotional changes, and possibly the total personality development of the fetus is quite fascinating. It is also hypothetical and difficult to appraise, for obvious reasons.

Part 2 contains Read's contribution and also a comparison between his method and hypnosis. Read denies the use of hypnosis in his conduct of labor. The authors wholeheartedly agree with many of his concepts. "The Read method has a great content of what the psychologists refer to as 'waking hypnosis' . . . [defined as] exaggerated suggestibility by artificial means." They are unable to decide whether this is caused by actual hypnosis or by heightened susceptibility to suggestion. The point seems rather labored in view of the clinically observable fact that pregnant women are highly suggestible.

The authors describe the use of both waking hypnosis (without unconsciousness) and deep hypnosis in pregnancy and labor and make a plea for their more widespread use. In a later chapter their uses are described in the treatment of other conditions.

Part 3 considers the relation of the emotions to endocrine functions, with special reference to the role of the hypothalamus. Under the heading, "Relation of Hormones to Behavior," there is a discussion of Selye's general adaptation syndrome and also of the possibility of variation of somatic characteristics of a genetic nature by emotional influence through the neuroendocrine system. This is an interesting speculation on the old problem of heredity versus environment.

References to the treatment of menstrual dysfunctions demonstrate how little we still know of the endocrinological problems here. The authors have had success with superficial psychotherapy and hypnotherapy in many cases and illustrative case histories are given.

Part 4 covers problems in which the psychic

component is very obvious, such as frigidity, vaginismus, and the menopause. There is also a discussion of the congestion-fibrosis syndrome, an entity recognized by older German and French gynecologists and brilliantly revived and documented by Taylor in 1949. This is one of the few extensive studies of a definite pathological condition for which a strong case for emotional etiology is presented by an outstanding gynecologist.

Part 5 discusses the technics available to the physician such as simple supportive therapy and the so-called insight therapy up to the more complicated procedures of psychoanalysis, hypnosis, hypnoanalysis, and narcosynthesis. The authors say, "The alert gynecologist will note that many of his patients inadvertently exaggerate the severity of their complaints as a means of getting what they want—namely, to avoid the responsibilities of a wife and/or mother, to gain more attention, to dominate their home environment —or they may unconsciously consider ailments as punishment for equally unconscious antisocial feelings, hostility, or deep-seated guilt." A great deal of what the authors have written has been in elucidation of the above statement and to enable the physician to recognize and prescribe the correct treatment.

This book is the result of much experience and painstaking work. The authors are aware of the controversial nature of some of their conclusions, but they have made an extremely valuable contribution to our knowledge and have provided a stimulus to further research.

—Dr. Jere B. Faison, *Associate Attending Physician in Gynecology and Obstetrics, St. Vincent's Hospital, New York City, and Obstetric Consultant, New York City Department of Health.*

TOWARD MANHOOD

Herman N. Bundesen, M.D. Philadelphia and New York, J. B. Lippincott Company. 1951. 175 p. $2.95.

Both in its title and its treatment this book is designed for the adolescent. It deals with the anatomy and function of the male and female reproductive systems and the usual range of problems in sex behavior. The concluding chapter offers quite limited advice regarding mate choice and marriage.

There can be no doubt about the essential soundness of the sex conduct which Dr. Bundesen urges upon his youthful readers in these pages. But there is, to say the least, much doubt about the way he handles his material. It is marred by some not too serious inaccuracy and obscured at times by technical and other words unfamiliar to most adolescents. Few medical men are able to write in vocabulary easily understood by laymen. Thus Bundesen writes of an ovum becoming "impervious" to sperms, a "vestigial" uterus, "gestating" an infant, a "flaccid" male organ, and "compunctions" about using a prostitute.

More serious are such matters as his reference to sex in terms of the "lower nature" and "animal nature," the implications in a statement to the effect that sex is a driving force which "will not be denied," the inclusion of a discussion of nymphomania, and the direct statement that "*the* [italics mine] reason why men of any age should control their sexual desires" is because of the risk of having a baby out of wedlock.

In any good educational approach to the teen-ager on the subject of sex every effort should be made to avoid the devaluation of the sex factor in human life by allusions to its nature in this fashion, and any possible inference, if nothing more, that sexual desire is an ungovernable drive. So, too, there seems to be no good reason for any treatment of a deviation like nymphomania in a book intended for reading by a thirteen-year-old. Finally, control of the sexual desire does not rest alone on the risk of begetting a child out of wedlock. Even if that certainly tragic outcome could be completely prevented there are many other and even more cogent reasons for self control.

Considered altogether, this book is not an important addition to the educational material for youth even though it quite definitely encourages sound sex behavior and often makes a good case for it.

—Roy E. Dickerson, *Executive Secretary, Cincinnati Social Hygiene Society.*

NUTRITION FOR HEALTH

H. F. Kilander, Ph.D. New York, McGraw-Hill Book Company, Inc. 1951. 415 p. $3.

This book contains up-to-date information about food and nutrition. Written in a readable manner it presents basic material that should help the high school student gain an understanding of nutrition and motivate him to adopt desirable food habits.

Each chapter ends with a review section, suggesting important questions on the material covered, and another section "for personal application" suggesting activities for students. These activities will help the student to apply the factual information to practical everyday situations and problems.

Many excellent illustrations and charts supplement the text and add to the interest of the book. The appendices include food value tables, tables of meals and meal analyses, tables for family food plans at low and moderate cost, a sample meal guide for one week, nutrition experiments, and a bibliography. They are a valuable part of the book.

Teachers and high school students will find this book of great value in their study of nutrition and health. Although it is written primarily for high school students it may be somewhat advanced for some. Teachers, nurses, public health workers, social workers, and others will also find it a practical and valuable nutrition reference.

—VIVIAN V. DRENCKHAHN, *Director, Health Education Service, National Tuberculosis Association.*

NURSING

KINESIOLOGY IN NURSING, LABORATORY MANUAL. Bernice Fash. New York, McGraw-Hill Book Company, Inc. 1952. 142 p. $2.80.

MEDICAL NURSING. Amy Frances Brown. Philadelphia, W. B. Saunders Company. 2nd edition. 1952. 1099 p. $5.50.

PUBLIC HEALTH

PREVENTIVE MEDICINE AND PUBLIC HEALTH. Wilson G. Smillie, M.D. New York, The Macmillan Company. 2nd edition. 1952. 603 p. $7.50.

CEREBRAL PALSY

OPPORTUNITIES LIMITED, A STUDY OF EMPLOYMENT PROBLEMS OF THE CEREBRAL PALSIED AND EPILEPTIC. Carolyn Brinn and Esther Elder Smith. San Francisco, California Society for Crippled Children. 1951. 116 p. Single copies free; $1 for each additional copy.

PROCEEDINGS—CEREBRAL PALSY INSTITUTE, 1950. Marguerite Abbott. New York, Association for the Aid of Crippled Children, Inc. 1952. 136 p. $1.50. Contains papers given at the Cerebral Palsy Institute held by the Coordinating Council of Greater New York in November 1950. The pediatric and clinical aspects are covered and various therapies —physical, occupational, and speech—from medical and technical viewpoints, inpatient and outpatient facilities, care of the child in his home and in the hospital, the role of the nurse, special education, vocational guidance, training and employment, and the parent's viewpoint are discussed. These papers will be of value to all professional workers contributing in any way to the rehabilitation of children with cerebral palsy.

PSYCHIATRY

FUNDAMENTALS OF PSYCHIATRY. Edward A. Strecker, M.D. Philadelphia, J. B. Lippincott Company. 5th edition. 1952. 250 p. $4.50.

NUTRITION

NUTRITION, UP TO DATE, UP TO YOU. Department of Agriculture. 1952. Write to Office of Information, U. S. Department of Agriculture, Washington 25, D.C., for free copy. Although there is more than enough food to go around many families are not getting the kinds and amount of foods they need. This booklet joins in the fight for good nutrition. It gives explanations of each of the food elements, tells what they do and where they are found, and includes a "food plan for good nutrition" which tells how to look for quality, how much food to buy for the number of servings planned, and how to store groceries.

CHILD WELFARE

SERVICES FOR CRIPPLED CHILDREN. Folder 38. Federal Security Agency, Children's Bureau. Washington 25, D.C., U. S. Government Printing Office. 1952. 27 p. 15c. Information in concise form on such subjects as where these services are located in each state, what they do, how such children are educated, auxiliary agencies.

POLIOMYELITIS

Two publications of The National Foundation for Infantile Paralysis, 120 Broadway, New York, distributed without charge.

POLIO IN RELATION TO CAMPING, for camp directors and counselors. Practical suggestions for camp directors, counselors, and nurses.

EARLY RECOGNITION OF THE MALADJUSTED CHILD.

(Continued on page A26)

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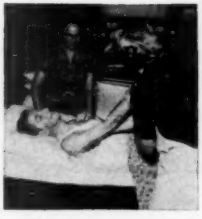

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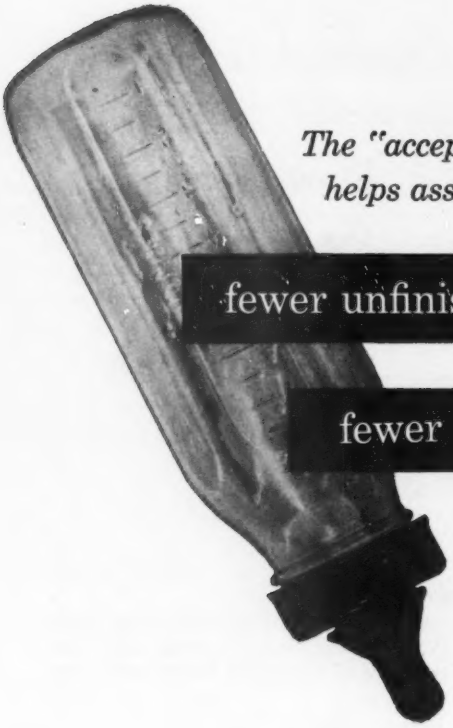

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1. Bruce, J. W., Hackett, L. J. and Bickel, J. E.: Feeding Premature Infants, J. Pediat. 35:201 (Aug.) 1949.

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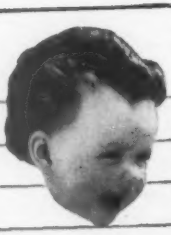

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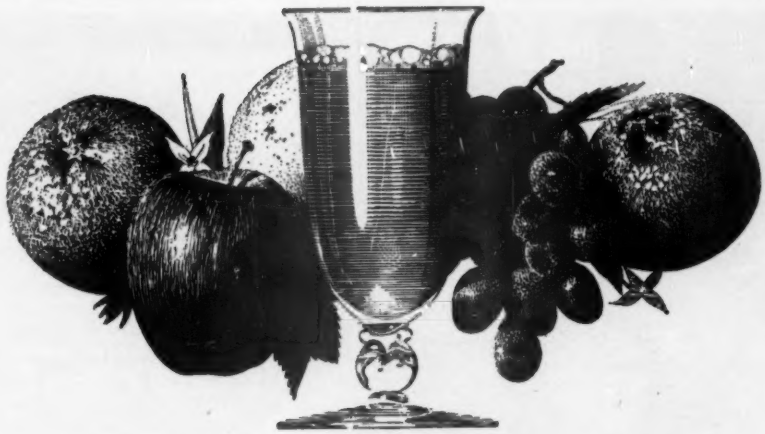
1. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

Juices need this advantage



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Orange juice	9.7	70.0
Pineapple juice	5.4	18.0
Apple juice	0.2	3.6
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What is true of a good breakfast applies to other meals. An adequate diet, including dairy foods and other protective foods, can be a great asset in increasing efficiency of workers and building national strength.

1. Tuttle, W. W., Daum, K., Myers, L., and Martin, C. Effect of omitting breakfast on the physiologic response of men. J. Am. Diet Assn. 26:332 (May) 1950
2. Orent-Keiles, E. and Hallman, L. F. The breakfast meal in relation to blood sugar values. U.S.D.A. Circ. 827. Washington, 1949
3. Leverton, R. M. and Gram, M. R. Nitrogen excretion of women related to the distribution of animal protein in daily meals. J. Nutr. 39:57(Sept.)1949

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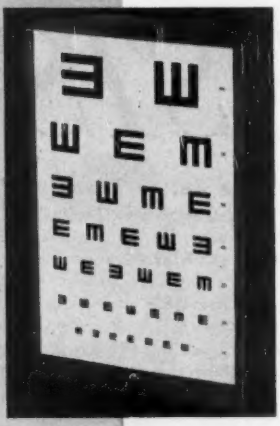

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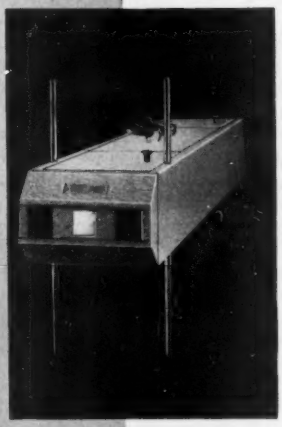

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. . . . that's the national need—

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. . . what is a Better Breakfast?

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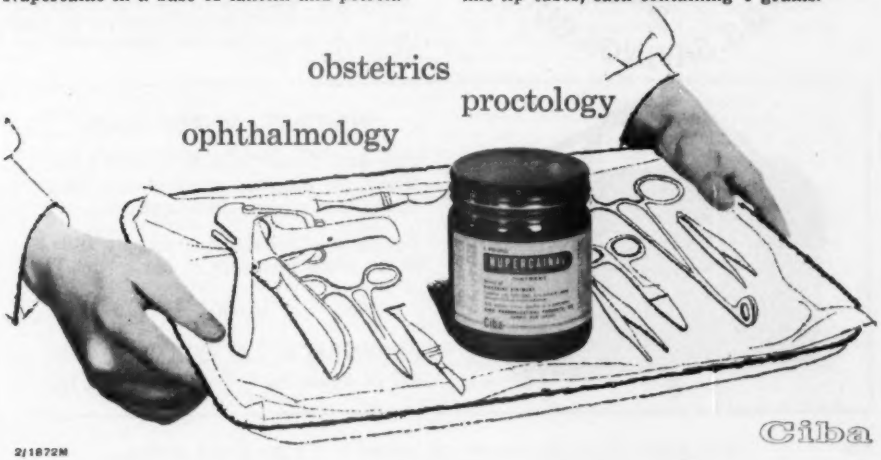

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(Continued from page 527)

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